

#### FLIGHT SAFETY FOUNDATION

**FEBRUARY-MARCH 1998** 

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# A Study of Fatal Approach-and-landing Accidents Worldwide, 1980–1996



#### FLIGHT SAFETY FOUNDATION

For Everyone Concerned With the Safety of Flight

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## **Flight Safety Digest**

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In This Issue

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#### A Study of Fatal Approach-and-landing Accidents Worldwide, 1980–1996

A study commissioned by the U.K. Civil Aviation Authority for Flight Safety Foundation examined in detail 287 fatal approach-and-landing accidents worldwide. Among the findings, were that 75 percent of the accidents occurred when a precision approach aid was not available or was not used; a disproportionate number of the accidents occurred at night; there were significant differences in the accident rates among world regions; and the leading causal factors were continuing the approach below decision height or minimum descent altitude in the absence of visual cues, and lack of positional awareness in the air.

#### NTSB Reports 1997 U.S. Airline Accident **42** Fatalities Lowest Since 1993

The record improved between 1996 and 1997, even though passenger enplanements increased by 35 million in 1997. The number and rate of accidents classified as "major" by the U.S. National Transportation Safety Board also decreased from 1996 to 1997.

#### Researchers Find That Redesigned Type III Exit Aids Evacuation in Test

New book offers comprehensive overview of communication navigation surveillance, air traffic management (CNS/ATM) system that will be the basis of the future air navigation system (FANS).

#### Incorrect Altimeter Setting Puts Aircraft 51 on Approach at 74 Meters Above Field Elevation While Eight Kilometers from Runway

Emergency helicopter strikes power line, killing pilot, nurses and accident victim who was being transported to trauma center.

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Flight Safety Foundation (FSF) is an international membership organization dedicated to the continuous improvement of flight safety. Nonprofit and independent, FSF was launched in 1945 in response to the aviation industry's need for a neutral clearinghouse to disseminate objective safety information, and for a credible and knowledgeable body that would identify threats to safety, analyze the problems and recommend practical solutions to them. Since its beginning, the Foundation has acted in the public interest to produce positive influence on aviation safety. Today, the Foundation provides leadership to more than 660 member organizations in 77 countries.

47

1





### A Study of Fatal Approach-and-landing Accidents Worldwide, 1980–1996

Study Commissioned by the U.K. Civil Aviation Authority Safety Regulation Group for Flight Safety Foundation

> Ronald Ashford Aviation and Safety Consultant Accident Analysis Group U.K. Civil Aviation Authority

Ronald Ashford's career in aviation began in 1953 with the de Havilland Aircraft Co., where he was a flight development engineer. After service in the Royal Air Force as a pilot officer, he returned to de Havilland — later Hawker Siddeley Aviation — as a flight test engineer on the Comet jet. In the U.K. Civil Aviation Authority (CAA) he held posts including head of flight engineering, head of the flight department, director general, airworthiness, and head of operational safety. He was appointed group director safety regulation and a CAA Board Member, and served as a member and chairman of the executive board of the European Joint Aviation Authorities until 1994. Since then, he has worked as an aviation and safety consultant. During his career, Ashford has received numerous honors and awards including the 1992 Flight Safety Foundation/Aviation Week and Space Technology Distinguished Service Award.

#### Contents

LAU	Executive Summary iii			
1.0	0 Introduction1			
2.0	The	Accident Analysis Group (AAG)	1	
3.0	Acc	ident Assessment	2	
	3.1	The Review Process	2	
	3.2	Causal Factors	2	
	3.3	Circumstantial Factors	2	
	3.4	Consequences	2	
	3.5	Level of Confidence	3	
	3.6	Summary of Assessments	3	
	3.7	Accident Rates	3	
4.0	Lim	itations of the AAG's Database	3	
5.0	Wor	ldwide Results	3	
	5.1	Fatal Accidents by Year	3	
	5.2	Fatalities by Year	3	
Data	۱ Supp	port Safety Actions Recommended by FSF Approach-and landing Accident Reduction Task Force	4	
		on Salety Actions Recommended by 151 Approach-and failding Accident Reduction Task Force	4	
	5.3	Phase of Flight		
	5.3 5.4		7	
		Phase of Flight	7 7	
	5.4	Phase of Flight Accident Locations by Region	7 7 8	
	5.4 5.5	Phase of Flight Accident Locations by Region Accidents by Region of Operator	7 7 8 9	
	5.4 5.5 5.6	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type	7 7 8 9 9	
	5.4 5.5 5.6 5.7	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes	7 7 8 9 9 9	
	5.4 5.5 5.6 5.7 5.8	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes Type of Approach	7 7 	
6.0	5.4 5.5 5.6 5.7 5.8 5.9 5.10	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes Type of Approach Night, Day, Twilight	7 7 	
6.0	5.4 5.5 5.6 5.7 5.8 5.9 5.10	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes Type of Approach Night, Day, Twilight Level of Confidence	7 7 	
6.0	5.4 5.5 5.6 5.7 5.8 5.9 5.10 Ana	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes Type of Approach Night, Day, Twilight Level of Confidence	7 7 8 9 9 9 9 10 10 10 10 10	
6.0	5.4 5.5 5.6 5.7 5.8 5.9 5.10 Ana 6.1 6.2	Phase of Flight Accident Locations by Region Accidents by Region of Operator Service Type Aircraft Classes Type of Approach Night, Day, Twilight Level of Confidence lysis of Primary Causal Factors Primary Causal Factors — Overall	7 7 	
	5.4 5.5 5.6 5.7 5.8 5.9 5.10 Ana 6.1 6.2	Phase of Flight Accident Locations by Region	7 7 	
	5.4 5.5 5.6 5.7 5.8 5.9 5.10 Ana 6.1 6.2 Ana	Phase of Flight	7 7 	

8.0 Analys	is of Circumstantial Factors	12
8.1 C	Circumstantial Factors — Overall	12
8.2 0	Circumstantial Factors by Aircraft Class	13
9.0 Analys	is of Consequences	13
9.1 C	Consequences — Overall	13
9.2 0	Consequences by Aircraft Class	13
10.0 Analys	is of Western-built Jets	13
10.1 F	Fatal Accidents by Year	14
10.2 F	Fatalities by Year	14
10.3 F	Fatal Accidents by Region of Operator	14
10.4 F	Fatal Accident Rates by Region of Operator	14
10.5 F	Fatal Accident Rates "Unlikely to be Exceeded," by Region of Operator	17
10.6 F	Fatalities by Region of Operator	17
10.7 F	Fatal Accident Rates for the JAA Countries and Other European Countries	19
11.0 Conclu	isions	19
References		21
Appendix 1	Factors and Consequences Attributed to Fatal Approach-and-landing Accidents	22
Appendix 2	Regions and Countries	
Appendix 3	Joint Aviation Authorities Full-member Countries	
Appendix 4.	1 Factors and Consequences Attributed to 92 Fatal Approach-and-landing Accidents in Western-built Jets	
Appendix 4.2	2 Factors and Consequences Attributed to 16 Fatal Approach-and-landing Accidents in Eastern-built Jets	30
Appendix 4.3	3 Factors and Consequences Attributed to 84 Fatal Approach-and-landing Accidents in Western-built Turboprops	33
Appendix 4.4	4 Factors and Consequences Attributed to 19 Fatal Approach-and-landing Accidents in Eastern-built Turboprops	
Appendix 4.5	5 Factors and Consequences Attributed to 76 Fatal Approach-and-landing Accidents in Business Jets	39

## **Executive Summary**

This report summarizes an analysis of fatal accidents to jet and turboprop airplanes that occurred during approach and landing between 1980 and 1996 inclusive. The sample covered 287 fatal accidents involving 7,185 fatalities to passengers and crew members and was based on the U.K. Civil Aviation Authority (CAA) database for its *Global Fatal Accident Review*. The primary conclusions of the analysis were:

- 1. Both the number of accidents and the number of fatalities showed an increasing trend overall. If the trend continues, by 2010 there will be 23 fatal approach-and-landing accidents (ALAs) with a total of 495 fatalities annually involving Western-built aircraft (commercial jets, business jets and turboprop airplanes) and operators, other than those of the Commonwealth of Independent States (C.I.S.);
- 2. A disproportionate number of ALAs occurred on flights without passengers (freight, ferry and positioning); the accident rate was judged to be nearly eight times higher than on passenger flights;
- 3. Seventy-five percent of the ALAs occurred when a precision approach aid was not available or was not used;
- 4. A disproportionate number of the accidents occurred at night; the accident rate at night is estimated to be three times that for day;
- 5. The fatal ALA rate for Western-built jets (excludes business jets) was highest for operators from Africa (2.43 per million flights), South America and Central America (1.65), and Europe other than the Joint Aviation Authorities (JAA) full-member countries (1.64). Australasian operators had no ALAs in the period;
- 6. Full-member JAA countries in Europe had a fatal ALA rate for Western-built jets ten times lower than the other European countries;
- The two most common primary causal factors, and most common of all causal factors, in ALAs were those in which the approach was continued below decision height or minimum descent altitude when no visual cues were available, and lack of positional awareness in the air, often resulting in a controlled-flight-into-terrain accident;
- 8. Aircraft built and operated in the Union of Soviet Socialist Republics or the C.I.S. (based on data for 1990–1996 only) had "press-on-itis" as the most common causal factor in ALAs, even though this was only sixth in the overall ranking; and,
- 9. The most frequent circumstantial factors were "nonfitment of presently available safety equipment" (generally ground-proximity warning system) and "failure in crew resource management." "Lack of ground aids" was cited in at least 25 percent of ALAs for all classes of aircraft.

### A Study of Fatal Approach-and-landing Accidents Worldwide, 1980–1996

A study commissioned by the U.K. Civil Aviation Authority for Flight Safety Foundation examined in detail 287 fatal approach-and-landing accidents. Among the findings, were that 75 percent of the accidents occurred when a precision approach aid was not available or was not used; a disproportionate number of the accidents occurred at night; there were significant differences in the accident rates among world regions; and the leading causal factors were continuing the approach below decision height or minimum descent altitude in the absence of visual cues, and lack of positional awareness in the air.

#### 1.0 Introduction

Flight Safety Foundation (FSF) has focused attention on approach-and-landing accidents (ALAs) as one of its major safety initiatives. In discussion in the FSF international Approach-and-landing Accident Reduction (ALAR) Task Force, it was agreed that the U.K. Civil Aviation Authority (CAA) database for its *Global Fatal Accident Review*<sup>1</sup> could be used as a starting point for a study of the global fatalaccident experience during approach and landing of jet and turboprop airplanes having greater than 5,700 kilograms (12,500 pounds) maximum takeoff weight (MTOW). The Global Fatal Accident Review analyzed 621 fatal accidents that occurred between 1980 and 1996 inclusive and, from these, 287 (46 percent) were judged to be in the approachand-landing phases of flight; the database of these 287 accidents forms the basis of this study, which was commissioned by the CAA for the Foundation.

#### 2.0 The Accident Analysis Group

To conduct its accident review, the CAA formed an Accident Analysis Group (AAG) early in 1996. The group comprised seven researchers, each having extensive aeronautical experience gained in both the aviation industry and the regulatory environment. The researchers brought to the AAG first-hand knowledge, for example, in the following areas:

- Commercial airline operations;
- Flight testing, handling and performance;
- Systems and structural design;
- Human factors and flight-deck design;
- Risk/safety analysis techniques;
- Cabin safety and survivability;
- Regulatory/legal procedures; and,
- Maintenance.

The AAG was established to study all worldwide fatal accidents to jet and turboprop airplanes having greater than 5,700 kilograms MTOW that occurred since 1980 during public transport, business, commercial training and

ferry/positioning flights. The following were excluded from the study:

- Piston-engine aircraft;
- Accidents resulting from acts of terrorism or sabotage;
- Fatalities to third parties not caused by the aircraft or its operation;
- Eastern-built aircraft and operators from the Union of Soviet Socialist Republics (U.S.S.R.) or Commonwealth of Independent States (C.I.S.) prior to 1990, because information from these countries was unavailable or limited at that time; and,
- Military-type operations or test flights.

Summaries of the accidents were obtained from the *World Aircraft Accident Summary*.<sup>2</sup> The summaries were usually brief and were supplemented with other information when required and available. At the AAG meetings, causal and circumstantial factors were discussed for each accident, and a consensus was reached on the factors to be allocated. These factors and any consequences were then recorded for each accident and entered in a fatal-accident database for future analysis. The AAG decided to assess all worldwide fatal accidents, unlike other studies in which only accidents where substantial information was available were reviewed; this was done to avoid any bias in the analysis toward accidents that have occurred in nations where detailed investigations are conducted and reports are issued. More details of the AAG approach are contained in Reference 1.

#### 3.0 Accident Assessment

#### 3.1 The Review Process

The review process accomplished by the AAG involved reaching consensus views to establish which causal factors, circumstantial factors and consequences occurred in each accident, together with an assessment of the level of confidence in the information available. In addition, a single primary causal factor was selected from the number of causal factors identified. Numbers of flights were also obtained from Airclaims (publisher of the *World Aircraft Accident Summary*) and other available sources.

#### 3.2 Causal Factors

A causal factor was an event or item that was judged to be directly instrumental in the causal chain of events leading to the accident. An event might be cited in the accident summary as being a causal factor, or it might be implicit in the text. Whenever an official accident report was quoted in the accident summary, the AAG used any causal factors stated therein for consistency; additionally, as stated above, the AAG selected one primary causal factor for each accident (though this proved to be difficult for some accidents). Where the choice was contentious, the group agreed on a particular method to select one primary causal factor, and then applied this method consistently to all other similar situations.

The causal factors were listed in generic groups and then broken down into specific factors, e.g., one causal group was "aircraft systems" and one of the several specific factors in this group was "system failure affecting controllability." The full list is shown in Appendix 1.

An accident could be allocated any number of causal factors from any one group and any combination of groups. In a single accident, the highest number of causal factors recorded was 10, which was allocated to an aircraft that undershot the runway.

#### 3.3 Circumstantial Factors

A circumstantial factor was an event or item that was judged not to be directly in the causal chain of events but could have contributed to the accident. These factors were present in the situation and were believed to be relevant to the accident, although not directly causal. For example, it was useful to note when an aircraft had made a controlled flight into terrain (CFIT) and it was not fitted with a ground-proximity warning system (GPWS). Because GPWS was not mandatory for all aircraft in the study and an aircraft can be flown safely without it, the nonfitment of GPWS in a CFIT accident was classed as a circumstantial factor rather than a causal factor.

"Failure in crew resource management (CRM)," when judged to be relevant, was in some situations allocated as a circumstantial factor and in others as a causal factor. The former was chosen when the accident summary did not clearly cite, or the data point to, CRM as a causal factor, but the AAG felt that had the CRM been to a higher standard, the accident might have been prevented. For example, CFIT during descent might have been avoided by good crew CRM (cross-checking by crew members, better coordination and division of duties, etc.), but the accident report or data might not have given sufficient evidence that CRM failure was a causal factor.

Circumstantial factors, like causal factors, were listed in generic groups and then broken down further into specific factors. The full list is shown in Appendix 1. For causal factors, an accident could be allocated any number of circumstantial factors from any one group and any combination of groups. The highest number of circumstantial factors recorded in a single accident was seven.

#### 3.4 Consequences

A list of consequences was used to record the outcomes of the fatal accidents in terms of collisions, structural failure, fire, fuel exhaustion and other events. It was important to keep a record of the consequences because all fatal accidents consist of a chain of events with a final outcome resulting in fatalities. In some accidents, it can be just as important to know what happened as why or how it happened, because a particular combination of causal factors on one day may lead to a fatal accident, while on another day, result in only a minor incident. In many events, the consequence is all that is remembered about a particular accident. The consequences are listed in Appendix 1. The highest number of consequences recorded in a single accident was five.

#### 3.5 Level of Confidence

The AAG also recorded the level of confidence for each accident. This could be high, medium or low and reflected the group's confidence in the accident summary and the factors allocated. It was not a measure of confidence in the allocation of individual factors but of the group's analysis of the accident as a whole. Alternatively, if the group believed that there was not enough substantive information in the accident summary (and there was no possibility of obtaining an official accident report), then there was a fourth level of confidence — insufficient information. For these accidents, no attempt was made to allocate causal factors, although there might have been circumstantial factors such as poor visibility that appeared to be relevant. Accidents with insufficient information were included in the analysis with allocated consequences (and sometimes circumstantial factors), even though there were no primary or other causal factors.

#### 3.6 Summary of Assessments

There were 64 possible causal factors, 15 possible circumstantial factors and 15 possible consequences, and each accident was allocated as many factors and consequences as were considered relevant. The group could allocate any combination of factors, although some factors are mutually exclusive. For example, factors A2.3 ("failure to provide separation in the air") and A2.4 ("failure to provide separation on the ground") would not be allocated to the same accident because the aircraft involved were either in the air or on the ground.

The recording of factors was based on judgments made on the available data, to ascertain the cause of the accident rather than to apportion blame.

#### 3.7 Accident Rates

Absolute numbers of accidents are obviously not a good indication of safety standards and are of no comparative value until they are converted to accident rates. For this purpose, it is possible to present the number of accidents per hour, per passenger-kilometer, per tonne-kilometer, etc., but the rate per flight is considered to be clearly the most useful indicator<sup>3</sup> and is used in this study.

The great majority of accidents (90 percent) occur in the phases of flight associated with takeoff and landing, and the length of the cruise phase has little influence on the risk. If you consider two operations with similar safety in the context of takeoff, approach and landing, of which one involves 10-hour flights and the other one-hour flights, to use a "per-hour" basis for the accident rate would give the former operation an accident rate that is close to one tenth of the latter (short-haul) operation; this was felt to be misleading. The fundamental objective is to complete each flight safely, regardless of its duration.

#### 4.0 Limitations of the AAG's Database

As with all statistics, care should be taken when drawing conclusions from the data provided. Only fatal accidents have been included in this study and therefore important events, including nonfatal accidents, serious incidents and "airprox" (insufficient separation between aircraft during flight) reports have not been covered. It is important to recognize these limitations when using the data.

The aggregated nature of the accident data, based on 287 accidents, tends to overcome errors of judgment, if any, made in analyzing individual accidents. A few errors of judgment would be unlikely to change the overall conclusions, especially because such errors might tend to balance one another.

#### 5.0 Worldwide Results

Because of the lack of information on the numbers of flights worldwide, accident rates have not been included in this section. Nevertheless, utilization data were available for Western-built jets, and accident rates are included in section 10.

#### 5.1 Fatal Accidents by Year

The group studied 287 worldwide fatal accidents during approach and landing that occurred between 1980 and 1996 inclusive. The numbers of fatal ALAs are shown by year in Figure 1 (page 7).

ALAs to Eastern-built aircraft and operators from the U.S.S.R. or C.I.S. were not included prior to 1990 because information was not available, was limited or was scarce.

There was an average of 12.1 accidents per year for the non-C.I.S. accidents in the first eight years of the study and 16.6 accidents per year in the last eight years; this shows a marked growth in the number of accidents. The average growth (best mean line) is 0.37 accidents per year; if this growth continued one could expect 23 fatal accidents to Western-built and Western-operated jets and turboprops (including business jets) annually by 2010.

#### 5.2 Fatalities by Year

The total ALAs resulted in 7,185 fatalities to passengers and crew members, an average of 25 fatalities per accident or 63 percent of the aircraft occupants, as shown in Figure 2 (page 8).

(continued page 7)

#### Data Support Safety Actions Recommended by FSF Approach-and-landing Accident Reduction Task Force

Flight Safety Foundation (FSF) presented the conclusions and recommendations of its work-in-progress to prevent approach-and-landing accidents (ALAs), during its 43rd annual Corporate Aviation Safety Seminar (CASS), May 5–7, 1998, in Hartford, Connecticut, U.S.

"There is a high level of confidence in these conclusions and recommendations," said Pat Andrews, manager, global aircraft services, Mobil Business Resources Corp., and cochair of the Operations and Training Working Group under the FSF international Approach-and-landing Accident Reduction (ALAR) Task Force. "Our confidence is based upon analysis of ALAs and a confidence check accomplished through the assessment of crew performance in line audits conducted under Professor Robert Helmreich at the University of Texas."

The task force's primary goal is to reduce commercial jet aircraft ALAs by 50 percent within five years after the task force's final recommendations, which are applicable to most aircraft operations, including business/corporate jet operations. Comprehensive ALA data have been collected and analyzed by the U.K. Civil Aviation Authority (CAA) in the study commissioned for the Foundation: "Study of Fatal Approach-and-landing Accidents 1980–1996." The study includes fatal ALAs worldwide for both jet and turboprop aircraft with a maximum takeoff weight greater than 12,500 pounds (5,700 kilograms).

"Available data make clear that our greatest efforts to prevent ALAs must be in Africa, Latin America and Asia," said Andrews.

The operations group, in developing its conclusions and recommendations, targeted all operations occurring from the commencement of an instrument approach or a visual approach, including circling, landing and missed-approach procedure.

Included in the group's recommendations are proposed tools to further help prevent ALAs. A document would provide comprehensive principles and guidelines to reduce risk associated with approach and landing operations, including specific information for management, flight operations, flight crews, dispatch/schedulers, air traffic controllers and airport managers. Planning guides for risk assessment, an educational video program and a CEO briefing are other proposed tools.

The nine conclusions and their respective recommendations are below:

1. Establishing and adhering to adequate standard operating procedures (SOPs) and crew resource

management (CRM) processes improves approach and landing safety.

- States should mandate and operators should develop/implement SOPs for approach and landing operations;
- Operators should develop SOPs that permit their practical application in a normal operating environment; input from flight crews is essential in the development and evaluation of SOPs;
- Operators should provide education and training that enhance flight crew decision-making and risk management (error management); and,
- Operators should implement routine and critical evaluation of SOPs to determine the need for change.
- 2. Improving communication and mutual understanding between air traffic control personnel and flight crews of each other's operational environment will improve approach and landing safety.

Specific recommendations are being developed to support this conclusion. Nevertheless, this conclusion suggests that CRM must be broadened to include a better-managed interface between flight crews and air traffic control personnel. Analysis reveals that compromises to approach and landing safety (e.g., rushed approaches) often result from misunderstanding or lack of knowledge about each other's operational environment.

- 3. Unstabilized and rushed approaches contribute to ALAs. Operators should define in their flight operations manuals the parameters of a stabilized approach and include at least the following:
  - 1. Intended flight path;
  - 2. Speed;
  - 3. Power setting;
  - 4. Attitude;
  - 5. Sink rate;
  - 6. Configuration; and,
  - 7. Crew readiness.

A suggested definition or policy that might be considered by operators:

All flights shall be stabilized by 1,000 feet (305 meters) height above touchdown (HAT). An approach is considered stabilized when the following criteria are met:

- The aircraft is on the correct flight path;
- Only small changes in heading and pitch are required to maintain the flight path;
- The aircraft speed is not more than V<sub>ref</sub> +20 knots indicated airspeed (KIAS) and not less than V<sub>ref</sub> -5 KIAS;
- The aircraft is in approach or landing configuration. Note that many light twin-engine airplanes have limited single-engine go-around capability and that they should not be configured for landing until the landing is assured;
- Sink rate is no more than 1,500 feet (457.5 meters) per minute;
- Power setting is minimum specified for type of aircraft; and,
- All briefings and checklists have been performed.

Specific types of approaches are considered stabilized if they also fulfill the following:

- Instrument landing system (ILS) approaches must be flown within one dot of the glide path or localizer, and a Category II approach or Category III approach must be flown within the expanded localizer band;
- Visual approaches wings must be level on final when the aircraft reaches 500 feet (152.5 meters) HAT;
- Circling approaches wings must be level on final when the aircraft reaches 300 feet (91.5 meters) HAT.
- Corporate policy should state that a go-around is required if the aircraft becomes unstabilized during the approach. Training should reinforce this policy.
- Before descent, a checklist-triggered risk assessment by the crew for the upcoming approach should be company SOP. Prior to commencement of the approach, the crew should confirm the risk assessment;
- The implementation of constant-angle and rate-ofdescent procedures for nonprecision approaches should be expedited globally; and,

- Training should be made available to flight crews for learning proper use of constant-angle descent procedures as well as approach-design criteria and obstacle-clearance requirements.
- 4. Failure to recognize the need for and to execute a missed approach when appropriate is a major cause of ALAs.
  - Company policy should specify go-around gates for approach and landing operations. Parameters should include:
    - Visibility minimums required prior to proceeding past the final approach fix (FAF) or the outer marker (OM);
    - Assessment at FAF or OM of crew readiness and aircraft readiness for the approach;
    - Minimum altitude at which the aircraft must be stabilized; and,
  - Companies should declare and support no-fault goaround and missed-approach policies.
- 5. The risk of ALAs is higher in operations conducted during conditions involving:
  - 1. Low light;
  - 2. Poor visibility;
  - 3. The likelihood of optical illusions; and,
  - 4. Wet or otherwise contaminated runways.
  - Tactical use should be made of a risk-assessment tool/checklist to identify hazards, the associated risks and appropriate procedures to reduce risks;
  - Operators should develop procedures to assist crews in planning and controlling approach angle and rate of descent during approaches; and,
  - Operators should develop a policy requiring the use of all available navigation and approach aids for each approach flown.
- 6. Using the radio altimeter as an effective tool will prevent ALAs.
  - Educational tools are needed to improve crew awareness of radio-altimeter operation and benefits;
  - Companies should state that the radio altimeter is to be used, and specify procedures for its use; and,
  - Manufacturers should design equipment that allows for native-language callouts.

- 7. When the pilot-in-command (PIC) is the pilot flying (PF), and the operational environment is complex, the task profile and workload reduce PF flight management efficiency and decision-making capability in approach and landing operations.
  - There should be a clear policy in the operator's manual defining the role of the PIC in complex and demanding flight situations; and,
  - Training should address the practice of transferring PF duties during operationally complex situations.
- 8. In-flight monitoring of crew/aircraft parameters (e.g., flight operations quality assurance [FOQA] program) identifies performance trends that operators can use to improve the quality of approach and landing operations. Performance improvement will result only if these data are managed sensitively and deidentified.
  - FOQA should be implemented worldwide in tandem with information-sharing partnerships such as Global Analysis and Information Network (GAIN), British Airways Safety Information System (BASIS) and Aviation Safety Action Programs (ASAP). Deidentification of data (i.e., pilots cannot be identified) must be a cardinal requirement;
  - Examples of FOQA benefits (safety and cost reductions) should be publicized widely; and,
  - A process should be developed to bring FOQA and information-sharing partnerships to regional airlines and business aviation.

### 9. Global sharing of aviation information decreases the risk of ALAs.

- Standardized global aviation phraseology should be used by all pilots and air traffic control personnel;
- FOQA and information-sharing partnerships should be implemented worldwide;
- Deidentification of aviation information data sources must be a cardinal requirement; and,
- Public awareness of the importance of information sharing must be increased in a coordinated, professional and responsible way.

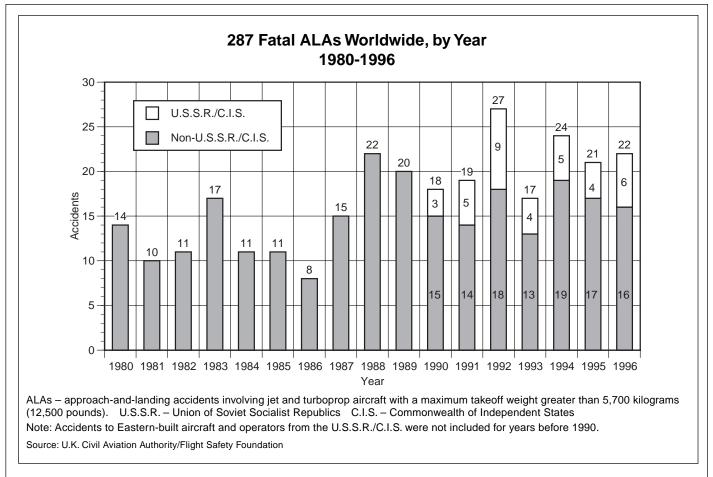
The FSF ALAR Task Force was created in June 1996 as a follow-on to the FSF international Controlled-flight-intoterrain (CFIT) Task Force. Both task forces have received widespread support from the aviation industry worldwide, including the International Civil Aviation Organization (ICAO) and the International Air Transport Association (IATA). Capt. Erik Reed Mohn, manager, governmental and external affairs, Scandinavian Airlines System (SAS) Flight Academy, co-chairs the operations group, which later created the Data Acquisition and Analysis Working Group to focus on analysis of ALA data and associated research. The data group is co-chaired by Ratan Khatwa, Ph.D., Rockwell-Collins, and Helmreich. Jean-Pierre Daniel, Airbus Industrie, chairs the Equipment Working Group, which was created in 1996 with the operations group, and will present detailed findings later this year.

The operations group includes representatives from AlliedSignal, Airbus Industrie, Air Line Pilots Association International (ALPA), Air Transport Association of America, American Airlines, AMR Eagle, Amsterdam Airport Tower, Amsterdam Airport Schiphol, Avianca, Avianca-SAM, Boeing Commercial Airplane Group, British Airways, China Southern Airlines, Delta Air Lines, Garuda Airlines, Hewlett-Packard, ICAO, KLM Cityhopper, Mexicana Airlines, National Research Laboratory (NLR)–Netherlands, Pakistan International Airlines, Rockwell-Collins, SAS, Transportation Safety Board (TSB) of Canada, University of Texas, U.S. National Transportation Safety Board (NTSB), US Airways and U.S. Aviation Underwriters.

The data group has undertaken three separate studies: the U.K. CAA's study of ALAs; a separate comprehensive study of 75 official ALA investigation reports, using a methodology that included CAA taxonomy, and found a high correlation between the CAA study of ALAs and the comprehensive study of 75 specific ALA accidents; and a study of 3,000 line audits that aimed to identify pre-cursors of accidents during normal flight operations.

Based on the three studies, the data group formulated conclusions and recommendations in air traffic control, airport authorities, flight crews, flight operations management, regulatory authorities and accident-incident investigation authorities. All these data have been used to develop other task force recommendations.

The data group includes representatives from Airbus Industrie, ALPA International, American Airlines, Amsterdam Airport Schiphol, Amsterdam Airport Tower, Australian Bureau of Air Safety Investigation, Aviacsa Aeroexo, The Boeing Co., British Aerospace, British Airways, Continental Airlines, Cranfield University Safety Center, Dutch ALPA, FlightSafety Boeing, Honeywell, IATA, ICAO, International Federation of Air Line Pilot's Association, KLM Cityhopper, NLR - Netherlands, NTSB, Rockwell-Collins, Southwest Airlines, TSB of Canada, U.K. Air Accidents Investigation Branch, U.K. CAA, and University of Texas.♦





In 1992, there were 970 fatalities, almost twice the annual average of 540 of the years 1990–1996 (in which U.S.S.R./ C.I.S. data are included).

In the first eight years of the study, there was an average of 300 fatalities per year for the non-U.S.S.R./C.I.S. accidents, compared with 428 for the last eight years. The "best mean line" growth was 6 percent per year. Though such growth continuing would lead to an annual average of 495 by 2010, there is reason to believe that the figures since 1992 may indicate improvement.

#### 5.3 Phase of Flight

The group allocated one of 14 phases of flight to its analysis of worldwide accidents, based on accident information from Airclaims.<sup>2</sup> This study looks more closely at the accidents in just three of these phases of flight, as shown in Table 1. The selection of flight phase was based on judgment rather than precise criteria.

Those accidents that occurred in other closely related phases, i.e., descent, hold and go-around, were not included. The accidents are fairly evenly distributed among the three phases of flight considered.

Table 1 287 Fatal ALAs Worldwide, By Phase of Flight 1980–1996		
Phase of Flight Fatal ALAs		
Approach	108	
Final approach	82	
Landing	97	
Total 28		

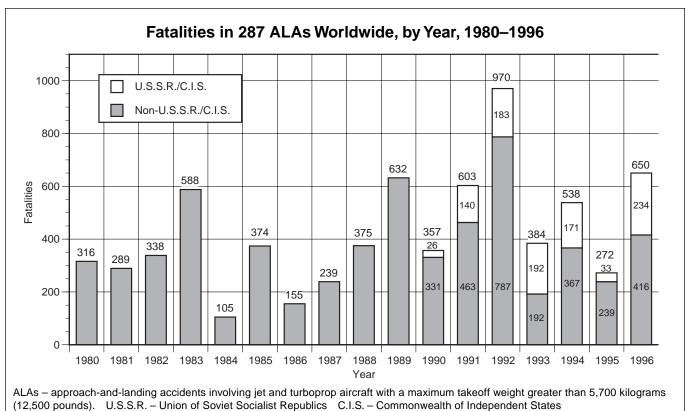
ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

#### 5.4 Accident Locations by Region

The number of ALAs in each of the world regions in which the 287 fatal accidents occurred is shown in Table 2 (page 8). The figures in the right-hand column show the percentage of



Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation



#### Table 2 287 Fatal ALA Locations, by Region\* 1980–1996

Region	Fatal ALAs	Percent of Region's Fatal Accidents
North America	74	44%
South/Central America	67	49%
Asia	43	35%
Africa	34	49%
Europe	62	57%
Australasia	7	50%
Total	287	

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990. \*Regions defined by Airclaims and shown in Appendix 2.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

the fatal accidents in *all* phases of flight in the region that occurred during the three approach-and-landing flight phases.

The regions are those defined by Airclaims (Appendix 2). "Europe," however, includes the U.S.S.R. and C.I.S.

To understand the full significance of these figures, one needs to know the numbers of relevant flights in each region and hence the accident rates; these figures are not currently available. (See section 10, page 13, for more comprehensive data on Western-built jets.)

The percentage of accidents occurring during approach and landing might be expected to reflect the frequency of bad weather, terrain problems and availability of precision approach aids. All regions, however, have figures of 50 percent  $\pm$  7 percent, except Asia, where such accidents are clearly a lower proportion of the total (35 percent).

#### 5.5 Accidents by Region of Operator

The accidents are shown in Table 3 (page 9) by region of operator. Because of the marked difference in regulatory arrangements between the two groups, Europe has been divided into the Joint Aviation Authorities (JAA) full-member countries (see Appendix 3) and the "rest of Europe," which includes JAA candidate members and nonmembers. (See 10.7, page 19.)

#### Table 3 287 Fatal ALAs Worldwide, By Region\* of Operator 1980–1996

Region	Fatal ALAs
North America	78
South/Central America	67
Asia	42
Africa	31
Europe	64
JAA full-member countries	30
All other European countries	34
Australasia	5
Total	287

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds).

U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States JAA – Joint Aviation Authorities Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

 $^{\ast}$  Regions defined by Airclaims and shown in Appendix 2.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

The distribution of fatal accidents by region of operator is not markedly different from the distribution of accident locations by region.

Again, the numbers of flights flown by all of the classes of aircraft covered and by region are not currently available, so that it was not possible to present accident rates.

#### 5.6 Service Type

The 287 fatal accidents occurred during the types of service shown in Table 4.

Though the actual numbers of flights for all classes of aircraft are not available, data indicate that there is a much higher accident rate on freight/ferry/positioning flights than on passenger flights. During the period 1990–1996 inclusive, 3.6 percent of the international and domestic flights during scheduled services of International Air Transport Association (IATA) members involved all-cargo flights.<sup>4</sup> CAA's data on fixed-wing air transport movements at U.K. airports<sup>5</sup> from 1986 to 1996 for aircraft having greater than 5,700 kilograms (12,500 pounds) MTOW showed that an average of 5 percent were allcargo flights; there was a steady increase in this period from 4.4 percent in 1986 to 5.6 percent in 1996. The average for the period covered in this study (1980–1996) is therefore estimated to be about 4.6 percent for U.K. airports.

These indications suggest that, overall, the freight/cargo operations together with ferry and positioning flights represent about 5 percent of the number of flights carried out in commercial transport operations. This indicates that the fatal accident rate on freight, ferry and positioning flights (i.e., when no fare-paying passengers are on board the aircraft) is some eight times higher than that for passenger flights. This is a surprising and important conclusion considering that the safety and operational standards that should be applied to such flights are generally no different from those for passenger flights.

#### Table 4 287 Fatal ALAs Worldwide, By Type of Service 1980–1996

Service	Fatal ALAs	Percent of 287 Fatal ALAs
Passenger	177	62%
Freight/ferry/positioning	73	25%
Business/other revenue	30	10%
Training/other nonrevenue	7	3%
Total	287	100%

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

#### 5.7 Aircraft Classes

The classes of aircraft involved in the accidents analyzed are shown in Table 5.

#### Table 5 287 Fatal ALAs Worldwide, By Class of Aircraft 1980–1996

Class	Fatal ALAs	Percent of 287 Fatal ALAs
Western-built jets	92	32%
Eastern-built jets	16	6%
Western-built turboprops	84	29%
Eastern-built turboprops	19	7%
Business jets	76	26%
Total	287	100%

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds).

U.S.S.R. – Union of Soviet Socialist Republics

C.I.S. – Commonwealth of Independent States Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

Accidents involving Western-built jets are reviewed in more detail in section 10.

#### 5.8 Type of Approach

In 169 (59 percent) of the accidents, the type of approach used was not known. The breakdown of the remainder is shown in Table 6.

#### Table 6 118 Fatal ALAs Worldwide, By Type of Approach 1980–1996

Type of Approach	Fatal ALAs	Percent of 118 Fatal ALAs*
Visual	49	41%
ILS or ILS/DME	30	25%
VOR/DME	16	13%
NDB	11	9%
VOR	10	8%
Other (SRA or DME)	2	4%
Total	118	100%

\*Where the type of approach was known.

ALAS – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States ILS – instrument landing system DME – distance measuring equipment VOR – very high frequency omnidirectional radio NDB – nondirectional beacon

SRA – surveillance-radar approach

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

Of those accidents where the type of approach was known, only 25 percent occurred during approaches and landings where a precision approach aid was available. It is suspected that precision approach aids were not available in some of the accidents where no information on the type of approach was found; if so, then much more than 75 percent of ALAs occurred when a precision approach aid was not available or not used.

#### 5.9 Night, Day, Twilight

It might be assumed that night approaches result in more difficulties caused, for example, by fewer visual cues or by spatial disorientation. Similarly, it is possible that the twilight hours could present particular problems. Where known, the ALAs have been allocated to day, night or twilight — the latter being broadly defined as times close to local sunrise and sunset. The results are shown in Table 7.

A global figure for the proportion of landings made at night is not known, but discussions with airlines and airfield operators

#### Table 7 287 Fatal ALAs Worldwide, by Time of Day 1980–1996

Time	Fatal ALAs	Percent of 287 Fatal ALAs
Day	143	50%
Night	112	39%
Twilight	5	2%
Not known	27	9%
Total	287	100%

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds).

U.S.S.R. – Union of Soviet Socialist Republics

C.I.S. - Commonwealth of Independent States

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

suggest that the figure is about 20 percent to 25 percent. If this is correct, then the rate for ALAs at night is nearly three times that for day. No conclusion can be drawn from the twilight figure.

When ALAs are broken down by aircraft class, business jets with 76 ALAs — suffered an even higher proportion of accidents at night. Of those 66 business-jet ALAs (87 percent) where the lighting conditions were known, 36 ALAs (55 percent) occurred at night and 27 ALAs (41 percent) occurred during daylight.

#### 5.10 Level of Confidence

The level of confidence reflected the group's confidence in the completeness of the accident summary and consequently the factors allocated for each accident, as detailed in 3.5. Of the 287 fatal ALAs, 152 were allocated a high level of confidence, as shown in Table 8 (page 11).

Causal factors were allocated to all but the eight accidents (3 percent) where there was believed to be insufficient information. The factors from all of the other accidents (279) were used in the analysis. There was little difference in the proportion of accidents allocated given levels of confidence for each aircraft class, e.g., 53 percent and 61 percent of those involving Western-built jets and turboprops, respectively, were allocated high levels of confidence.

#### 6.0 Analysis of Primary Causal Factors

#### 6.1 Primary Causal Factors — Overall

In the accident review carried out by the AAG, any number of causal factors may have been allocated, with one identified to

Table 8		
Level of Confidence in Completeness of		
Accident Summary of 287 Fatal		
ALAs Worldwide		
1980–1996		

Level	Fatal ALAs	Percent of 287 Fatal ALAs
High	152	53%
Medium	104	36%
Low	23	8%
Insufficient information	8	3%
Total	287	100%

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics

C.I.S. - Commonwealth of Independent States

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990. Source: U.K. Civil Aviation Authority/Flight Safety Foundation

be the primary causal factor. Of the 287 ALAs, eight were judged to have insufficient information available, leaving 279 for which causal factors were allocated.

The most frequently identified primary causal factors in the overall sample of 279 accidents are shown in Table 9.

These five most frequently identified primary causal factors (out of a possible 64) account for 71 percent of the accidents. All five primary causal factors are from the "crew" causal group, indicating that crew factors were involved.

In these ALAs, the most common primary causal factor, "omission of action/inappropriate action," generally referred to the crew continuing the descent below the decision height (DH) or minimum descent altitude (MDA) without visual reference, or when visual cues were lost. The second most frequent factor, "lack of positional awareness in the air," generally involved a lack of appreciation of the aircraft's proximity to high ground, frequently when the aircraft was not equipped with a GPWS and/or when precision approach aids were not available; these were generally CFIT accidents.

Considering the causal groups ("A" in Appendix 1), rather than individual factors, "crew" featured in 228 of the 279 accidents (82 percent), followed by "environmental" in 14 (5 percent).

The complete summaries of causal factors allocated, including primary causal factors, are shown in Appendix 4.

#### 6.2 Primary Causal Factors by Aircraft Class

When each aircraft class is considered separately, there are considerable differences in the most frequently identified

#### Table 9 Most Frequent Primary Causal Factors In 279 Fatal ALAs Worldwide 1980–1996

Primary Causal Factor*/**	Fatal ALAs	Percent of 279 Fatal ALAs
Omission of action/ inappropriate action	69	24.7%
Lack of positional awareness in the air	52	18.6%
Flight handling	34	12.2%
"Press-on-itis"	31	11.1%
Poor professional judgment/airmanship	12	4.3%
Total	198**	

\*For which sufficient information was known to allocate causal factors.

\*\*Some ALAs had primary causal factors not among the five most frequent primary causal factors.

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990. Source: U.K. Civil Aviation Authority/Flight Safety Foundation

primary causal factors. Table 10 (page 12) shows the ranking of various primary factors for each class; the figures in parentheses are the percentages of the accidents for that aircraft class.

It is noteworthy that for the aircraft built and operated in the U.S.S.R./C.I.S., "press-on-itis" is the most frequent primary cause, but this is generally fourth in the ranking for other aircraft classes. "Flight handling" ranks first for Western-built turboprops, even though it is only third overall.

#### 7.0 Analysis of All Causal Factors

#### 7.1 All Causal Factors — Overall

As stated, the AAG allocated any number of causal factors to each accident. Frequently, an accident results from a combination of causal factors, and it is important to see the overall picture (the other contributing factors as well as the primary causal factor) rather than just the single primary factor. For this part of the analysis, primary factors have been included along with all others. The average number of causal factors allocated was 3.8. The largest number of causal factors allocated was 10.

The most frequently identified causal factors in the sample of 279 accidents are shown in Table 11 (page 13).

# Table 10Ranking of Primary Causal Factors in 279 Fatal ALAs Worldwide, by Aircraft Class1980–1996

Primary Causal Factor	Overall Ranking	Western-built Jets	Eastern-built Jets	Western-built Turboprops	Eastern-built Turboprops	Business Jets
Omission of action/ inappropriate action	1 (24.7%)	1 (27.4%)	= 2 (12.5%)	3 (17.1%)	2 (18.7%)	1 (31.1%)
Lack of positional awareness in the air	2 (18.6%)	2 (16.5%)	= 2 (12.5%)	= 1 (19.5%)	3 (12.5%)	2 (20.3%)
Flight handling	3 (12.2%)	= 3 (9.9%)	= 4 (6.3%)	= 1 (19.5%)	= 4 (6.3%)	3 (9.5%)
"Press-on-itis"	4 (11.1%)	= 3 (9.9%)	1 (31.2%)	4 (8.5%)	1 (37.5%)	= 4 (5.4%)
Poor professional judgment/airmanship	5 (4.3%)	5 (5.5%)	•	= 6 (3.7%)	•	= 4 (5.4%)
Deliberate nonadherence to procedures	6 (2.9%)	= 7 (2.2%)	•	= 8 (2.4%)	= 4 (6.3%)	= 6 (4.1%)
Wind shear/upset/ turbulence	7 (2.2%)	= 7 (2.2%)	= 4 (6.3%)	= 6 (3.7%)	•	•
Failure in CRM (cross-check/coordinate)	8 (1.8%)	= 14 (1.1%)	•	5 (4.9%)	•	•
Icing	= 9 (1.4%)	•	•	= 11 (1.2%)	= 4 (6.3%)	= 8 (2.7%)
System failure • flight deck information	= 9 (1.4%)	= 14 (1.1%)	= 4 (6.3%)	= 11 (1.2%)	•	=10 (1.4%)

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States CRM – crew resource management • – No fatal ALAs were attributed to this primary causal factor in this class of aircraft.

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Note: The complete list of primary causal factors has been shortened for this table. Factors that ranked high in the overall list (first column) sometimes ranked lower for specific types of aircraft. In some instances, two or more primary causal factors occurred in equal numbers of accidents, and the factors were assigned equal rankings. For example, some columns may contain two 3s, three 4s, etc.

In several instances, a factor shown in the table occurred in equal numbers of accidents with a factor not shown because the factor not shown was not among those ranked 1 through 9 in the "overall ranking" column.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

The figures in the right-hand column indicate the proportion of the 279 accidents to which the particular causal factor was allocated; remember that each accident usually has several factors applied to it. Once again, all the five causal factors most frequently selected were in the "crew" causal group.

The three most frequently identified causal factors each appear in about 40 percent or more of all accidents.

#### 7.2 All Causal Factors by Aircraft Class

The ranking of the various most frequent causal factors is shown for each aircraft class in Table 12 (page 14).

Again, "press-on-itis" appears as the most frequent, or equally most frequent, causal factor for aircraft built and operated in the C.I.S., whereas it ranked only sixth overall. "Deliberate nonadherence to procedures" is seen also to be more frequent for the C.I.S. aircraft than for Western-built and -operated jets; to a lesser extent, business jets also rank higher on this factor.

#### 8.0 Analysis of Circumstantial Factors

#### 8.1 Circumstantial Factors — Overall

As stated in 3.3, a circumstantial factor was an event or aspect that was not directly in the causal chain of events but could have contributed to the accident. The average number of circumstantial factors was 2.7. The most frequently identified circumstantial factors in the sample of 279 accidents are shown in Table 13 (page 15).

The "nonfitment of presently available safety equipment" referred, in the great majority of accidents, to the lack of GPWS or, in some cases, lack of enhanced GPWS of the type that is now (even if not at the time of the accident) available; this was intended to estimate how many accidents such equipment might prevent in the future.

"Failure in CRM" also ranked high as a causal factor. A judgment was made as to whether the lack of good CRM was actually one of the causes that led to the accident, in

#### Table 11 Most Frequent Causal Factors In 279 Fatal ALAs Worldwide 1980–1996

Causal Factor*	Cited in Fatal ALAs	Percent of 279 Fatal ALAs
Lack of positional awareness in the air	132	47.3%
Omission of action/ inappropriate action	121	43.4%
Slow and/or low on approach	109	39.1%
Flight handling	81	29.0%
Poor professional judgment/airmanship	68	24.3%
Total	511**	

\* For which sufficient information was known to allocate causal factors.

\*\* Most ALAs had multiple causal factors.

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds).

U.S.S.R. – Union of Soviet Republics

C.I.S. – Commonwealth of Independent States

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

which case it was allocated as a causal factor, or inadequate CRM appeared to be present, and if it had been to a higher standard, might have helped to prevent the accident (i.e., a circumstantial factor).

#### 8.2 Circumstantial Factors by Aircraft Class

The ranking of the most frequent circumstantial factors is shown for each aircraft class in Table 14 (page 15).

There is some consistency in the five circumstantial factors that occur most frequently, except for Eastern-built turboprops. The "nonfitment of presently available safety equipment" (essentially GPWS) was judged to be a factor in 47 percent of all ALAs. "Failure in CRM" was also a factor in at least 37 percent of all the aircraft groups. Lack of ground aids — basically, the lack of a precision approach aid or navigational aid — was an important factor (at least 25 percent of the accidents) across aircraft classes.

#### 9.0 Analysis of Consequences

#### 9.1 Consequences — Overall

As stated before, consequences are not seen as part of the causes of accidents, but are relevant to a complete

understanding of the accident history. A full list of the 15 consequences considered is shown in Appendix 1. The average number of consequences allocated was 1.9. Consequences were allocated even to those accidents (eight) that the AAG considered to have insufficient information for the selection of causal or circumstantial factors. The most frequently identified consequences in this sample of 287 ALAs are shown in Table 15 (page 16).

"Collision with terrain/water/obstacle" and "CFIT" were the most frequent consequences. The former implied that control of the aircraft had been lost (i.e., "loss of control in flight" would also have been allocated), or severe weather or some other factor had contributed to the impact; "CFIT," on the other hand, was allocated when the aircraft was flown into the ground and under full control. Where the impact with terrain occurred in circumstances where it was not clear whether or not the aircraft was under control, the former consequence was applied; this almost certainly underestimates the number of CFIT accidents.

Postimpact fire occurred in nearly a quarter of the accidents (and probably occurred in more). It should be noted that "postimpact fire" was given as a consequence whenever it was known to have occurred. It also appears for some accidents as a causal factor; this indicates that in these accidents it was judged to have contributed to the fatalities. (See 7.2, page 12.)

"Undershoots" can be seen to have been involved in many fatal accidents; "overruns" were features of about half as many accidents — presumably because overruns are less often fatal, rather than because they occur less often.

#### 9.2 Consequences by Aircraft Class

The ranking of the most frequent consequences is shown for each aircraft class in Table 16 (page 16).

The pattern of consequences is moderately consistent. "Collision with terrain/water/obstacle" is the most frequently cited consequence overall and in three of the five aircraft classes. But Eastern-built jets have "overrun" as a consequence at nearly twice the frequency of the overall sample.

#### 10.0 Analysis of Western-built Jets

This section presents an analysis of Western-built jet airliner operations by world regions; business jets are in a separate class. Airclaims has provided utilization data, including numbers of flights flown annually for this category of aircraft. The fatal accident rates are shown in relation to the number of flights, which provide the most useful and valid criterion to indicate safety standards. (See 3.7, page 3.)

Ninety-two of the 287 fatal ALAs (32 percent) involved Western-built jets.

# Table 12Ranking of All Causal Factors in 279 Fatal ALAs Worldwide, by Aircraft Class1980–1996

Causal Factor	Overall Ranking	Western-built Jets	Eastern-built Jets	Western-built Turboprops	Eastern-built Turboprops	Business Jets
Lack of positional awareness in the air	1 (47.3%)	1 (44.0%)	= 1 (43.7%)	2 (42.7%)	2 (37.5%)	1 (59.5%)
Omission of action/ inappropriate action	2 (43.4%)	1 (44.0%)	3 (37.5%)	1 (43.9%)	= 3 (31.2%)	3 (45.9%)
Slow and/or low on approach	3 (39.1%)	3 (35.2%)	4 (31.2%)	4 (39.0%)	= 3 (31.2%)	2 (47.3%)
Flight handling	4 (29.0%)	5 (27.5%)	= 6 (18.7%)	3 (40.2%)	= 5 (25.0%)	5 (21.6%)
Poor professional judgment/airmanship	5 (24.3%)	4 (30.8%)	= 9 (12.5%)	7 (19.5%)	= 7 (18.7%)	4 (25.7%)
"Press-on-itis"	6 (21.5%)	6 (17.6%)	= 1 (43.7%)	6 (20.7%)	1 (50.0%)	6 (16.2%)
Failure in CRM (cross-check/coordinate)	7 (15.8%)	7 (16.5%)	= 6 (18.7%)	5 (22.0%)	•	8 (10.8%)
Postimpact fire	= 8 (11.8%)	= 8 (14.3%)	= 9 (12.5%)	= 8 (13.4%)	= 10 (12.5%)	12 (6.8%)
Deliberate nonadherence to procedures	= 8 (11.8%)	= 17 (6.6%)	= 6 (18.7%)	10 (11.0%)	= 5 (25.0%)	7 (14.9%)

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). C.I.S. – Commonwealth of Independent States CRM – crew resource management • – No fatal ALAs were attributed to this causal factor in this class of aircraft.

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Note: The complete list of all causal factors has been shortened for this table. Factors that ranked high in the overall list (first column) sometimes ranked lower for specific types of aircraft. In some instances, two or more factors occurred in equal numbers of accidents, and the factors were assigned equal rankings. For example, some columns may contain two 3s, three 4s, etc. In several instances, a factor shown in the table occurred in equal numbers of accidents with a factor not shown because the factor not shown was not among those ranked 1 through 8 in the "overall ranking" column.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

#### 10.1 Fatal Accidents by Year

The 92 fatal accidents are shown in Figure 3 (page 17).

The number of accidents per year in Western-built jets averages between five per year and six per year, with an increasing trend over the period of the study; the average growth (best mean line) is 0.11 accidents per year. One might hope, however, that the figures since 1992 indicate a decreasing trend.

#### 10.2 Fatalities by Year

The 92 fatal accidents during approach and landing to Western-built jets between 1980 and 1996, inclusive, resulted in 4,696 fatalities to passengers and crew, as shown in Figure 4 (page 18). This gives averages of 51 fatalities per accident and 276 fatalities per year. The overall number of fatalities divided by the number of occupants (passengers and crew) in all the accidents gives a measure of average survivability; this figure is 61 percent.

In the first eight years of the 17-year period, there were 1,804 fatalities compared with 2,662 in the last eight years; this

suggests a significantly worsening trend. The growth rate overall (best mean line) averages 4.5 fatalities per year. Both the number of accidents and the number of fatalities are growing by between 1 percent and 2 percent per year. A continuing increase in the number of accidents and the number of fatalities is likely to become unacceptable to the public, unless the trend is definitely checked or reversed.

#### 10.3 Fatal Accidents by Region of Operator

The fatal ALAs for Western-built jets between 1980 and 1996 are shown in Figure 5 (page 18) by region of the operator; there were no such accidents in Australasia.

Europe is shown by the 19 full-member JAA countries in Europe and the other European countries. (See 10.7, page 19.)

#### 10.4 Fatal Accident Rates by Region of Operator

When the numbers of flights are applied to give the fatal accident rates per million flights of Western-built jets for ALAs, the comparisons are different, as shown in Figure 6 (page 19).

# Table 13Ranking of Most Frequent Circumstantial Factors in 279 Fatal ALAs Worldwide1980–1996

Circumstantial Factor*	Cited in Fatal ALAs	Percent of 279 Fatal ALAs
Nonfitment of presently available safety equipment (GPWS, TCAS, wind-shear warning, etc.)	132	47.3%
Failure in CRM (cross-check/coordinate)	131	47.0%
Weather (other than poor visibility, runway condition)	103	36.9%
Poor visibility	89	31.9%
Lack of ground aids	81	29.0%
Total	536**	

\*For which sufficient information was known to allocate circumstantial factors.

\*\*More than one circumstantial factor could be allocated to a single accident.

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States GPWS – ground-proximity warning system TCAS – traffic-alert and collision avoidance system CRM – crew resource management Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990. Source: U.K. Civil Aviation Authority/Flight Safety Foundation

#### Table 14 Ranking of Most Frequent Circumstantial Factors in 279 Fatal ALAs Worldwide, By Aircraft Class 1980–1996

Circumstantial Factor	Overall Ranking	Western-built Jets	Eastern-built Jets	Western-built Turboprops	Eastern-built Turboprops	Business Jets
Nonfitment of presently available safety equipment (GPWS, TCAS, wind-shear warning, etc.)	1 (47.3%)	1 (44.0%)	= 1 (50.0%)	2 (46.3%)	7 (12.5%)	1 (59.5%)
Failure in CRM (cross-check/coordinate)	2 (47.0%)	2 (41.8%)	= 1 (50.0%)	3 (45.1%)	= 3 (37.5%)	2 (56.8%)
Other weather (other than poor visibility, runway condition)	3 (36.9%)	4 (28.6%)	3 (43.7%)	1 (50.0%)	1 (50.0%)	5 (28.4%)
Poor visibility	4 (31.9%)	3 (31.9%)	= 5 (25.0%)	4 (30.5%)	6 (31.2%)	3 (35.1%)
Lack of ground aids	5 (29.0%)	= 5 (25.3%)	4 (31.2%)	= 5 (26.8%)	= 3 (37.5%)	4 (33.8%)
Inadequate regulatory oversight	6 (23.7%)	= 5 (25.3%)	= 5 (25.0%)	5 (26.8%)	2 (43.7%)	7 (13.5%)

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States

GPWS – ground-proximity warning system CRM – crew resource management TCAS – traffic-alert and collision avoidance system Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./ C.I.S. were not included for years before 1990.

Note: The complete list of most frequent circumstantial factors has been shortened for this table. Factors that ranked high in the overall list (first column) sometimes ranked lower for specific types of aircraft. In some instances, two or more factors occurred in equal numbers of accidents, and the factors were assigned equal rankings. For example, some columns may contain two 3s, three 4s, etc. In several instances, a factor shown in the table occurred in equal numbers of accidents with a factor not shown because the factor not shown was not among those ranked 1 through 6 in the "overall ranking" column.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

# Table 15Most Frequently Identified Consequences in 287 Fatal ALAs Worldwide1980–1996

Consequence	Cited in Fatal ALAs	Percent of 287 Fatal ALAs
Collision with terrain/water/obstacle	131	45.6%
Controlled flight into terrain (CFIT)	120	41.8%
Loss of control in flight	74	25.8%
Postimpact fire	65	22.6%
Undershoot	50	17.4%
Total	440*	

\*Some accidents had multiple consequences.

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States

Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R. and C.I.S. were not included for years before 1990.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

# Table 16Ranking of Identified Consequences in 287 Fatal ALAs Worldwide, by Aircraft Class1980–1996

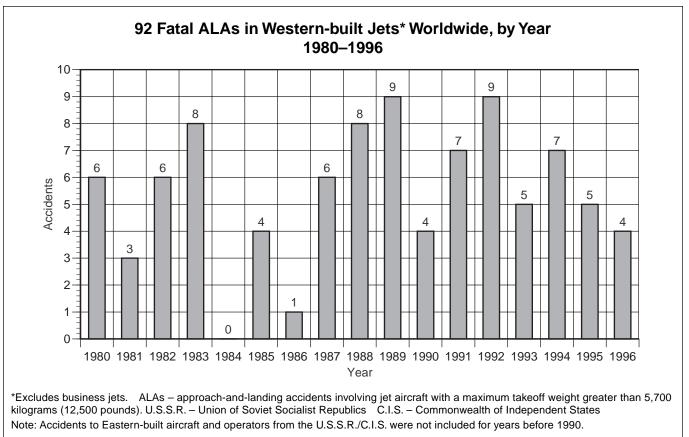
Consequence	Overall Ranking	Western-built Jets	Eastern-built Jets	Western-built Turboprops	Eastern-built Turboprops	Business Jets
Collision with terrain/water/ obstacle	1 (44.6%)	1 (48.9%)	= 2 (31.2%)	1 (50.0%)	1 (47.8%)	2 (39.5%)
Controlled flight into terrain (CFIT)	2 (41.8%)	2 (34.8%)	1 (56.2%)	2 (40.5%)	= 2 (31.6%)	1 (51.3%)
Loss of control in flight	3 (25.8%)	4 (22.8%)	= 6 (6.2%)	3 (38.1%)	= 2 (31.6%)	4 (18.4%)
Postimpact fire	4 (22.6%)	3 (27.2%)	= 4 (18.7%)	4 (17.9%)	= 5 (12.5%)	3 (26.3%)
Undershoot	5 (17.4%)	5 (18.5%)	= 2 (31.2%)	5 (16.7%)	= 5 (12.5%)	5 (15.8%)
Overrun	6 (9.8%)	6 (14.1%)	4 (18.7%)	6 (6.0%)	= 5 (12.5%)	= 6 (6.6%)
Ground collision with object/obstacle	7 (7.0%)	7 (10.9%)	= 6 (6.2%)	= 9 (2.4%)	= 5 (12.5%)	= 6 (6.6%)

ALAs – approach-and-landing accidents involving jet and turboprop aircraft with a maximum takeoff weight greater than 5,700 kilograms (12,500 pounds). U.S.S.R. – Union of Soviet Socialist Republics C.I.S. – Commonwealth of Independent States Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

Note: The complete list of identified consequences has been shortened for this table. Identified consequences that ranked high in the overall list (first column) sometimes ranked lower for specific types of aircraft. In some instances, two or more identified consequences occurred in equal numbers of accidents, and the identified consequences were assigned equal rankings. For example, some columns may contain two 3s, three 4s, etc. In several instances, a factor shown in the table occurred in equal numbers of accidents with a factor not shown because the factor not shown was not among those ranked 1 through 7 in the "overall ranking" column.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

Africa, South and Central America, and Asia are well above the world average, Africa by a factor of more than five. Australasia, North America and, to a lesser extent, Europe are below the world average. Europe is broken down into the JAA and the other European countries in section 10.7. Australasia's excellent record of zero fatal accidents merits further consideration. This is against a background of 5.3 million flights; this can be compared, for example, with the North American sample of 14 fatal accidents in 110.8 million flights. If Australasia had the same underlying accident rate







as North America, one would expect, on average, one accident every 7.9 million flights; not having had an accident in 5.3 million flights does not necessarily indicate that the Australasian region is any better than North America. Though the record in Australasia is good, one must be very cautious in interpreting this result. (See also 10.5.)

### **10.5** Fatal Accident Rates "Unlikely to Be Exceeded," by Region of Operator

When analyzing a small number of events, the accident rates derived may not be a reliable indication of the true underlying rates. An accepted method in such a situation is to employ the Poisson distribution to determine the maximum fatal accident rates, to a given level of confidence, within which range the underlying rates are likely to fall. For this analysis, this method was applied to determine the accident rate which, to a 95 percent confidence level, is unlikely to be exceeded. This provides pessimistic figures for the accident rates, for which there is only a 5 percent probability that the true underlying rates will exceed.

These rates unlikely to be exceeded are determined by:

• Considering the number of fatal accidents for each population;

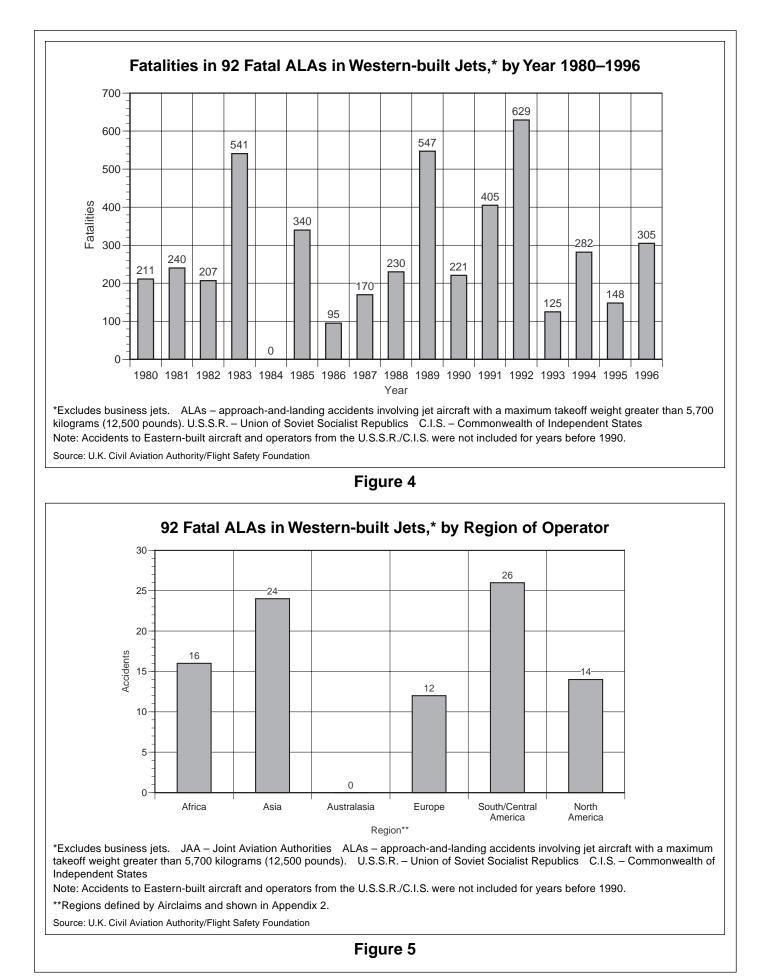
- Determining, using Poisson distribution data, the number of fatal accidents that is unlikely to be exceeded to the defined level of confidence (95 percent); and,
- Dividing this latter figure by the number of flights to obtain a fatal accident rate that is equally unlikely to be exceeded.

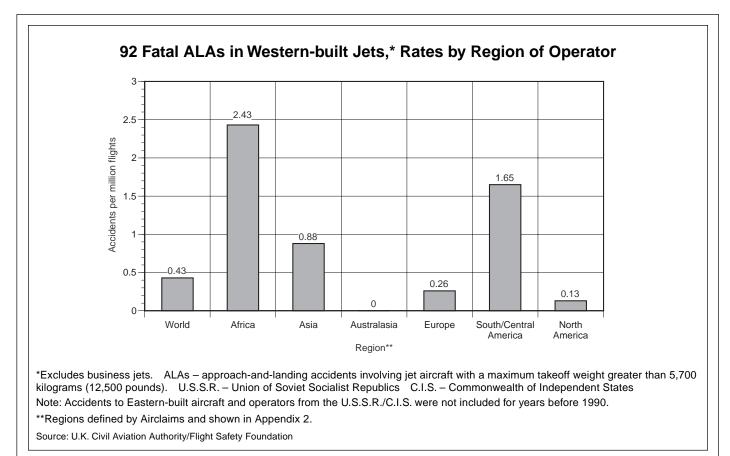
The accident rates that the underlying rates are unlikely to exceed are shown in Figure 7 (page 20).

Note that when a 95 percent level of confidence is applied to the fatal accident rates, Australasian operators have a notional accident rate figure, which is unlikely to be exceeded, of 0.57 per million flights rather than the actual rate of zero. This takes into account the relatively few flights accrued by operators in that region.

#### **10.6 Fatalities by Region of Operator**

The number of fatalities occurring in Western-built jets in ALAs between 1980 and 1996 inclusive was 4,696. The figures are shown by region of operator in Figure 8 (page 21).





#### Figure 6

### **10.7** Fatal Accident Rates for the JAA Countries and Other European Countries

As mentioned earlier, Europe is divided into the JAA countries, which use a common set of safety regulations and comprise 19 full-member countries, and the other European countries. Of the 12 fatal ALAs involving European operators (Figure 5, page 17), seven involved JAA operators and five involved operators from the other European countries. The numbers of flights for each group of countries were 42.8 million and 3.04 million respectively. This gives the following fatal accident rates for approach-and-landing accidents:

- JAA full-member countries: 0.164 per million flights; and,
- Other European countries: 1.640 per million flights.

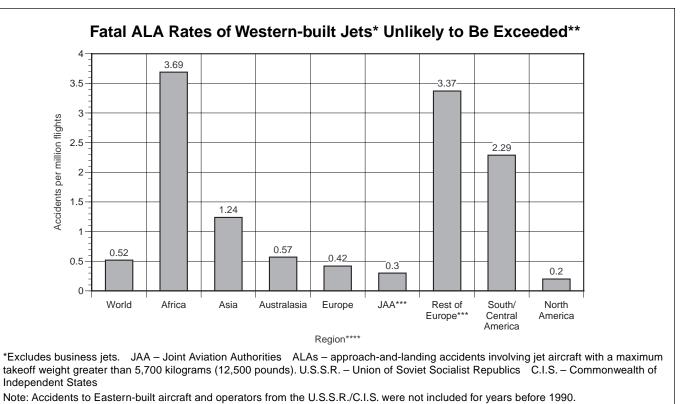
The JAA full-member countries, therefore, have an accident rate 10 times better than the other European countries, and comparable with North America.

#### **11.0 Conclusions**

An analysis has been carried out to establish the primary causal factors, causal factors, circumstantial factors and consequences of the 287 fatal accidents recorded on the U.K. CAA database for its *Global Fatal Accident Review* that occurred during

approach, final approach and landing.<sup>1</sup> This covered all such known accidents to jet and turboprop airplanes having greater than 5,700 kilograms (12,500 pounds) MTOW, including business jets, between 1980 and 1996. It excluded test flights and accidents resulting from terrorism and sabotage; Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were excluded prior to 1990. The following main conclusions were drawn:

- 1. There was an average of 14.8 fatal accidents during approach and landing per year for non-U.S.S.R./C.I.S. aircraft. There was an increasing trend that, if continued, would result in 23 fatal accidents annually by 2010;
- 2. The overall number of fatalities to passengers and crew members from all ALAs in the period was 7,185. The non-C.I.S. aircraft can be expected to suffer 495 fatalities annually by 2010 if the overall trend continues;
- 3. Of the 287 accidents, the majority occurred to aircraft used by operators from North America, South and Central America and Europe; most flights occurred in these regions. Only five accidents involved operators from Australasia;
- 4. Sixty-two percent of the accidents occurred during passenger operations and 25 percent occurred during freight, ferry and positioning flights when no passengers were carried. These figures cannot reflect the relative number of flights flown for these purposes



\*\*At 95 percent confidence level

\*\*\*Data for Europe are divided to show rates for the 19 full-member JAA countries and the other European countries.

\*\*\*\*Regions defined by Airclaims and shown in Appendix 2.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation

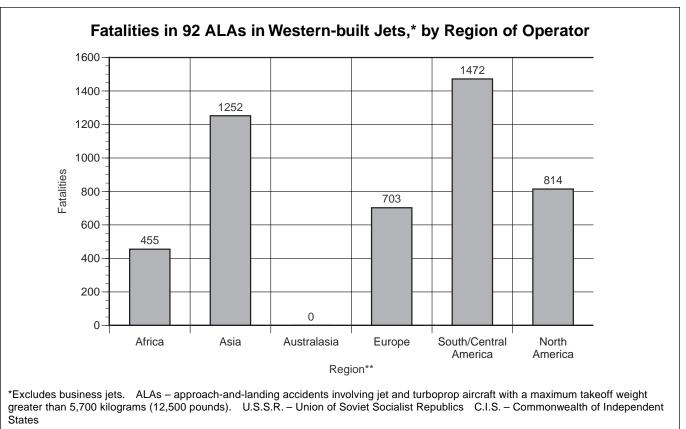
#### Figure 7

and suggest a far higher accident rate on freight, ferry and positioning flights — possibly eight times higher;

- 5. For accidents where the type of approach was known, 75 percent occurred when a precision approach aid was not available or was not used;
- 6. Fifty percent of the accidents occurred during daylight, 39 percent occurred during night and 2 percent occurred during twilight. Though the exact proportions of night and day approaches are not known, it seems likely that the accident rate at night is close to three times that for day;
- 7. Business jets suffered more accidents on night approaches and landings than by day;
- 8. Fatal accidents to Western-built jets on approach and landing average five per year to six per year, and there is an overall increasing trend during the period of the study. Fatalities average 276 per year and are increasing. The average number of fatalities is 51 per accident, and 61 percent of the aircraft occupants;
- 9. Most fatal accidents to Western-built jets occurred to operators from South and Central America and Asia. (See 10 below.);
- 10. The fatal accident rate for Western-built jets was highest for Africa (2.43 per million flights) and South and

Central America (1.65 per million flights). Australasia had no fatal accidents to Western-built jets;

- 11. When Europe is divided into the 19 full-member JAA countries and the other European countries, JAA countries have an accident rate for Western-built jets (0.16 per million flights) that is 10 times lower than that for the other European countries;
- 12. The most common primary causal factor was judged to be "omission of action/inappropriate action." This most often referred to the crew continuing the descent below the DH or MDA without visual reference or when visual cues were lost;
- 13. The second most common primary causal factor, "lack of positional awareness in the air," generally related to CFIT accidents;
- 14. When all causal factors (primary and contributory) are considered, the most frequent are those referred to above as primary causal factors, plus "slow and/or low on approach," "flight handling" and "poor professional judgment/airmanship";
- 15. Aircraft built and operated in the U.S.S.R./C.I.S. had "press-on-itis" as the most frequent causal factor, even though this was only sixth in the overall ranking;



Note: Accidents to Eastern-built aircraft and operators from the U.S.S.R./C.I.S. were not included for years before 1990.

\*\*Regions defined by Airclaims and shown in Appendix 2.

Source: U.K. Civil Aviation Authority/Flight Safety Foundation



- 16. The most frequent circumstantial factors were "nonfitment of presently available safety equipment" (generally GPWS) and "failure in CRM." "Lack of ground aids" was cited in at least 25 percent of accidents for all classes of aircraft; and,
- 17. The most frequent consequences were "collision with terrain/water/obstacle," and "CFIT." These were followed by "loss of control in flight," "postimpact fire" and "undershoot." Eastern-built (U.S.S.R./C.I.S.) jets had fatal overruns as a consequence at nearly twice the frequency of the overall sample. ♦

#### References

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- 4. International Air Transport Association (IATA). World Air Transport Statistics IATA Members' Air Transport Operations.
- 5. U.K. CAA Economic Regulation Group. "Fixed Wing Air Transport Movements at U.K. Airports" (unpublished note, Dec. 22, 1997).

#### Further Reading from FSF Publications

Enders, J.H. et al. "Airport Safety: A Study of Accidents and Available Approach-and-landing Aids." *Flight Safety Digest* Volume 15 (March 1996): 1–36.

Khatwa, R.; Roelen, A.L.C. "An Analysis of Controlled-flightinto-terrain (CFIT) Accidents of Commercial Operators, 1988 through 1994." *Flight Safety Digest* Volume 15 (April–May 1996): 1-45.

Flight Safety Foundation. "Dubrovnik-bound Flight Crew's Improperly Flown Nonprecision Instrument Approach Results in Controlled-flight-into-terrain Accident." *Flight Safety Digest* Volume 15 (July–Aug. 1996): 1–25.

#### Appendix 1 Factors and Consequences Attributed to Fatal Approach-and-landing Accidents

Α	Causal Group		Causal Factor
A.1	Aircraft systems	1.1	System failure — affecting controllability
		1.2	System failure — flight deck information
		1.3	System failure — other
A.2	Air traffic control/Ground aids	2.1	Incorrect or inadequate instruction/advice
		2.2	Misunderstood/missed communication
		2.3	Failure to provide separation in the air
		2.4	Failure to provide separation on the ground
		2.5	Ground aid malfunction or unavailable
A.3	Environmental	3.1	Structural overload
		3.2	Wind shear/upset/turbulence
		3.3	lcing
		3.4	Wake turbulence — aircraft spacing
		3.5	Volcanic ash/sand/precipitation, etc.
		3.6	Birds
		3.7	Lightning
		3.8	Runway condition unknown to crew
A.4	Crew	4.1	Lack of positional awareness in the air
		4.2	Lack of positional awareness on the ground
		4.3	Lack of awareness of circumstances in flight
		4.4	Incorrect selection on instrument/navaid
		4.5	Action on wrong control/instrument
		4.6	Slow/delayed action
		4.7	Omission of action/inappropriate action
		4.8	"Press-on-itis"
		4.9	Failure in crew resource management (cross-check/coordinate)
		4.10	Poor professional judgment/airmanship
		4.11	Disorientation or visual illusion
		4.12	Fatigue
		4.12	State of mind
		4.14	Interaction with automation
		4.15	Fast and/or high on approach
		4.15	Slow and/or low on approach
		4.10	
		4.17	Loading incorrect
			Flight handling
		4.19 4.20	Lack of qualification/training/experience
			Incapacitation/medical or other factors reducing crew performance
		4.21	Failure in look-out
^ =	Engine	4.22 5.1	Deliberate nonadherence to procedures
A.5	Engine	-	Engine failure or malfunction
		5.2	Propeller failure
		5.3	Damage due to noncontainment
		5.4	Fuel contamination
	Fire	5.5	Engine failure simulated
A.6	Fire	6.1	Engine fire or overheat
		6.2	Fire due to aircraft systems
		6.3	Fire — other cause
		6.4	Postimpact fire
A.7	Maintenance/Ground handling	7.1	Failure to complete due maintenance
		7.2	Maintenance or repair error/oversight/inadequacy
		7.3	Ground staff or passenger(s) struck by aircraft
		7.4	Loading error
		7.5	Bogus parts

#### Appendix 1 Factors and Consequences Attributed to Fatal Approach-and-landing Accidents

(continued)

Structure	8.1	Corrosion/fatigue
	8.2	Overload failure
	8.3	Flutter
Infrastructure	9.1	Incorrect, inadequate or misleading information to crew
	9.2	Inadequate airport support
Design		Design shortcomings
		Unapproved modification
		Manufacturing defect
Performance		Unable to maintain speed/height
		Aircraft becomes uncontrollable
Other		Caused by other aircraft
	12.2	Nonadherence to cabin safety procedures
Circumstantial Group		Circumstantial Factor
Aircraft systems	1.1	Nonfitment of presently available safety equipment (ground-proximity warning system, traffic-alert and collision avoidance system, wind-shear warning, etc.
	1.2	Failure/inadequacy of safety equipment
Air traffic control/Ground aids	2.1	Lack of air traffic control
	2.2	Lack of ground aids
Environmental	3.1	Poor visibility
	3.2	Weather
	3.3	Runway condition (ice, slippery, standing water, etc.)
Crew	4.1	Training inadequate
	4.2	Presented with situation beyond training
	4.3	Failure in crew resource management (cross-check/coordinate)
Infrastructure	5.1	Incorrect/inadequate procedures
	5.2	Company management failure
	5.3	Inadequate regulation
	5.4	Inadequate regulatory oversight
Other	6.1	Illegal/unauthorized/drug smuggling flight
Consequence		
Controlled flight into terrain (CF	IT)	
Collision with terrain/water/obst	acle	
Midair collision		
Ground collision with other aircr	aft	
Ground collision with object/obs	stacle	
Loss of control in flight		
Fuel exhaustion		
Overrun		
Undershoot		
Structural failure		
Postimpact fire		
Fire/smoke during operation		
•	es	
Other cause of fatality		
-	и.~	
or confidence.		h Medium Low Insufficient information
-	Infrastructure Design Performance Other Circumstantial Group Aircraft systems Air traffic control/Ground aids Environmental Crew Infrastructure Other Consequence Controlled flight into terrain (CF Collision with terrain/water/obst Midair collision Ground collision with other aircr Ground collision with other ai	8.2         8.3         Infrastructure       9.1         9.2         Design       10.1         10.2       10.3         Performance       11.1         11.2       10.2         Other       12.1         Air traffic control/Ground aids       2.1         Air traffic control/Ground aids       2.1         2.2       2.2         Environmental       3.1         3.2       3.3         Crew       4.1         4.2       4.3         Infrastructure       5.1         5.2       5.3         5.4       5.4         Other       6.1         Consequence       5.1         Kidair collision with terrain/water/obstacle       5.3         Midair collision with other aircraft       5.4         Other       6.1         Consequence       5.1         Kidair collision with other aircraft       5.2         Ground collision with other aircraft       5.4         Other       6.1         Dess of control in flight       5.2         Loss of control in flight       5.2         Fuel exhaustion       5.4 </td

#### Appendix 2 Regions\* and Countries

#### Africa

Algeria Angola Benin Botswana Burkina Faso Burundi Cameroon Cape Verde Islands Central African Republic Chad Ciskei Comoros Congo Democratic Republic of Congo Djibouti Egypt Ethiopia Gabon Gambia Ghana Guinea Guinea-Bissau Ivory Coast Kenya Lesotho Liberia Libya Madagascar Malawi Mali Mauritania Mauritius Morocco Mozambique Namibia Niger Nigeria Republic of Bophuthatswana Rwanda Sao Tome and Principe Senegal Seychelles Sierra Leone Somalia South Africa Sudan Swaziland Tanzania Togo Tunisia Uganda Zambia Zimbabwe

#### Asia

Afghanistan Bahrain Bangladesh Bhutan Brunei Cambodia China Hong Kong India Indonesia Iran Iraq Israel Japan Jordan Korea Kuwait Laos Lebanon Macau Malaysia Maldives Mongolia Myanmar Nepal Oman Pakistan Palestine Philippines Qatar Saudi Arabia Singapore Sri Lanka Syria Taiwan Thailand Vietnam Yemen Australasia American Samoa Australia Cook Islands Fiji French Polynesia Guam Kiribati Marshall Islands Nauru New Caledonia

New Zealand

Northern Marianas Islands

Pacific Islands Palau Papua New Guinea Solomon Islands Tonga Vanuatu Western Samoa

#### Europe

JAA full-member countries in **bold** and C.I.S. countries in *italic*:

Albania Armenia Austria Azerbaijan Belarus Belgium Bosnia-Herzegovina Bulgaria Croatia Cyprus Czechoslovakia **Czech Republic** Denmark Estonia Faroe Islands Finland France Georgia Germany Gibraltar Greece Greenland Hungary Iceland Ireland Italy Kazakstan Kyrgyzstan Latvia Lichtenstein Lithuania Luxembourg Macedonia Malta Moldova Monaco Montenegro Netherlands Norway Poland **Portugal** Romania

#### Appendix 2 Regions and Countries (continued)

Russia Serbia Slovakia Slovenia **Spain Sweden Switzerland** *Tajikistan* Turkey *Turkmenistan Ukraine* **United Kingdom** U.S.S.R. *Uzbekistan* Yugoslavia

#### **North America**

Anguilla Antigua & Barbuda Aruba Bahamas Barbados Bermuda Canada

\*Regions defined by Airclaims

Cayman Islands Cuba Dominica **Dominican Republic** Grenada Guadeloupe Haiti Jamaica Martinique Montserrat Puerto Rico St. Kitts & Nevis St. Lucia St. Pierre & Miquelon Trinidad & Tobago St. Vincent & the Grenadines Turks & Caicos Islands United States Virgin Islands (U.S. and British)

Brazil Chile Colombia Costa Rica Ecuador El Salvador Falkland Islands French Guyana Guatemala Guyana Honduras Mexico Nicaragua Panama Paraguay Peru Suriname Uruguay Venezuela

#### South/Central America

Argentina Belize Bolivia

#### Appendix 3 Joint Aviation Authorities Full-member Countries

- Austria
- Belgium
- Denmark
- Finland
- France
- Germany
- Greece

- Iceland
- Ireland
- Italy
- Luxembourg
- Monaco
- Netherlands
- Norway

- Portugal
- Spain
- Sweden
- Switzerland
- United Kingdom

				Numb	Number of Times Cited in Accidents	Accidents
	Causal Factor			Primary	Causal	Total
A.1	Aircraft systems	1.1	System failure — affecting controllability	2	7	6
		1.2	System failure — flight deck information	~	2	ю
		1.3	System failure — other	0	4	4
A.2	Air traffic control/Ground aids	2.1	Incorrect or inadequate instruction/advice	~	0	10
		2.2	Misunderstood/missed communication	0	4	4
		2.3	Failure to provide separation in the air	0	2	7
		2.4	Failure to provide separation on the ground	<del>.</del>	۲-	2
		2.5	Ground aid malfunction or unavailable	0	2	7
	Environmental	3.1	Structural overload	0	0	0
		3.2	Wind shear/upset/turbulence	2	ω	10
		3.3	Icing	0	0	0
		3.4	Wake turbulence — aircraft spacing	0	0	0
		3.5	Volcanic ash/sand/precipitation, etc.	0	7	2
		3.6	Birds	0	0	0
		3.7	Lightning	0	0	0
		3.8	Runway condition unknown to crew	~	С	4
	Crew	4.1	Lack of positional awareness in the air	15	25	40
		4.2	Lack of positional awareness on the ground	0	0	0
		4.3	Lack of awareness of circumstances in flight	0	4	-
		4.4	Incorrect selection on instrument/navaid	0	2	7
		4.5	Action on wrong control/instrument	0	4	-
		4.6	Slow/delayed action	2	6	11
		4.7	Omission of action/inappropriate action	25	15	40
		4.8	"Press-on-itis"	6	7	16
		4.9	Failure in crew resource management (cross-check/coordinate)	~	14	15
		4.10	Poor professional judgment/airmanship	5	23	28
		4.11	Disorientation or visual illusion	0	e	с
		4.12	Fatigue	0	ო	с
		4.13	State of mind	<del>.</del>	0	-
		4.14	Interaction with automation	2	Ð	7
		4.15	Fast and/or high on approach	0	0	6
		116		c	37	33

				Num	Number of Times Cited in Accidents	n Accidents
	Causal Factor			Primary	Causal	Total
		4.17	Loading incorrect	0	0	0
		4.18	Flight handling	6	16	25
		4.19	Lack of qualification/training/experience	0	9	9
		4.20	Incapacitation/medical or other factors reducing crew performance	0	~	~
		4.21	Failure in look-out	0	2	2
		4.22	Deliberate nonadherence to procedures	2	4	9
	Engine	5.1	Engine failure or malfunction	0	4	4
		5.2	Propeller failure	0	0	0
		5.3	Damage due to noncontainment	0	-	~
		5.4	Fuel contamination	0	0	0
		5.5	Engine failure simulated	0	0	0
	Fire	6.1	Engine fire or overheat	~	0	~
		6.2	Fire due to aircraft systems	~	0	-
		6.3	Fire — other cause	ო	0	с
		6.4	Postimpact fire	0	13	13
	Maintenance/Ground handling	7.1	Failure to complete due maintenance	0	0	0
		7.2	Maintenance or repair error/oversight/inadequacy	7	0	2
		7.3	Ground staff or passenger(s) struck by aircraft	0	0	0
		7.4	Loading error	0	0	0
		7.5	Bogus parts	0	0	0
	Structure	8.1	Corrosion/fatigue	0	-	£
		8.2	Overload failure	0	7	7
		8.3	Flutter	0	0	0
	Infrastructure	9.1	Incorrect, inadequate or misleading information to crew	0	7	7
		9.2	Inadequate airport support	-	ę	4
A.10	Design	10.1	Design shortcomings	-	12	13
		10.2	Unapproved modification	0	0	0
		10.3	Manufacturing defect	0	-	-
A.11	Performance	11.1	Unable to maintain speed/height	0	4	4
		11.2	Aircraft becomes uncontrollable	0	8	8
A.12	Other	12.1	Caused by other aircraft	-	0	~
		12.2	Nonadharance to cabin cafety procedures	C	C	C

	<b>Circumstantial Factor</b>			Number of Times Cited in Accidents
В.1	Aircraft systems	1.1	Nonfitment of presently available safety equipment (ground-proximity warning	OF
		, ,	פאפורוו, וומוווט-מוכו נמוט טטוואטון מעטנמוטכ אאפווו, אווט-אוכמו אמוזוווץ, כוט. בהווינה/ההלההלהמיניהי הל הקהני המנוהשהמי	, c
с Ц	Air traffic control (Cround aide	- с і ғ	railure/irrauequacy of safety equipriferit. Look of air traffic control	у с
ч. О		- c v v	Lack of an induity control	2 50
c C			Lack of ground ards	23
н. В	Environmental	3.1	Poor visibility	29
		3.2	Weather	26
		3.3	Runway condition (ice, slippery, standing water, etc.)	7
B.4	Crew	4.1	Training inadequate	7
		4.2	Presented with situation beyond training	0
		4.3	Failure in crew resource management (cross-check/coordinate)	38
B.5	Infrastructure	5.1	Incorrect/inadequate procedures	13
		5.2	Company management failure	18
		5.3	Inadequate regulation	8
		5.4	Inadequate regulatory oversight	23
B.6	Other	6.1	Illegal/unauthorized/drug smuggling flight	0
с	Consequence			Number of Times Cited in Accidents
<u>.</u>	Controlled flight into terrain (CFIT)	Ē		32
C.2	Collision with terrain/water/obstacle	cle		45
C.3	Midair collision			-
C.4	Ground collision with other aircraft	aft		1
C.5	Ground collision with object/obstacle	acle		10
C.6	Loss of control in flight			21
C.7	Fuel exhaustion			Ω
C.8	Overrun			13
C.9				17
C.10	D Structural failure			2
C.1	1 Postimpact fire			25
C.12	2 Fire/smoke during operation			4
C.13	3 Emergency evacuation difficulties	s		4
C.14	4 Forced landing — land or water			ю
C.15	5 Other cause of fatality			0
ы Ш х	* Except business jets			
Leve	Level of confidence	49 High	36 Medium 6 Low 1 Insufficient information	

				Numk	Number of Times Cited in Accidents	n Accidents
	Causal Factor			Primary	Causal	Total
1	Aircraft systems	1.1	System failure — affecting controllability	0	0	0
		1.2	System failure — flight deck information	-	-	7
		1.3	System failure — other	0	-	-
	Air traffic control/Ground aids	2.1	Incorrect or inadequate instruction/advice	0	0	0
		2.2	Misunderstood/missed communication	0	0	0
		2.3	Failure to provide separation in the air	0	0	0
		2.4	Failure to provide separation in the ground	0	0	0
		2.5	Ground aid malfunction or unavailable	0	0	0
	Environmental	3.1	Structural overload	0	0	0
		3.2	Wind shear/upset/turbulence	←	0	-
		3.3	Icing	0	0	0
		3.4	Wake turbulence — aircraft spacing	0	0	0
		3.5	Volcanic ash/sand/precipitation, etc.	0	0	0
		3.6	Birds	0	0	0
		3.7	Lightning	0	0	0
		3.8	Runway condition unknown to crew	0	0	0
	Crew	4.1	Lack of positional awareness in the air	4	ю	7
		4.2	Lack of positional awareness on the ground	0	0	0
		4.3	Lack of awareness of circumstances in flight	0	0	0
		4.4	Incorrect selection on instrument/navaid	0	0	0
		4.5	Action on wrong control/instrument	0	0	0
		4.6	Slow/delayed action	0	-	-
		4.7	Omission of action/inappropriate action	4	2	9
		4.8	"Press-on-itis"	5	2	7
		4.9	Failure in crew resource management (cross-check/coordinate)	0	с	က
		4.10	Poor professional judgment/airmanship	0	2	7
		4.11	Disorientation or visual illusion	0	0	0
		4.12	Fatigue	0	-	-
		4.13	State of mind	0	0	0
		4.14	Interaction with automation	0	0	0
		4.15	Fast and/or high on approach	0	4	4
		416	Slow and/or low on annoach	c	Ľ	ſ

				Numbe	Number of Times Cited in Accidents	Accidents
A	Causal Factor			Primary	Causal	Total
		4.17	Loading incorrect	0	0	0
		4.18	Flight handling	~	2	က
		4.19	Lack of qualification/training/experience	0	0	0
		4.20	Incapacitation/medical or other factors reducing crew performance	0	0	0
		4.21	Failure in look-out	0	0	0
		4.22	Deliberate nonadherence to procedures	0	ю	ę
A.5	Engine	5.1	Engine failure or malfunction	0	0	0
		5.2	Propeller failure	0	0	0
		5.3	Damage due to noncontainment	0	0	0
		5.4	Fuel contamination	0	0	0
		5.5	Engine failure simulated	0	0	0
A.6	Fire	6.1	Engine fire or overheat	0	0	0
		6.2	Fire due to aircraft systems	0	-	-
		6.3	Fire — other cause	0	0	0
		6.4	Postimpact fire	0	2	7
A.7	Maintenance/Ground handling	7.1	Failure to complete due maintenance	0	0	0
		7.2	Maintenance or repair error/oversight/inadequacy	0	0	0
		7.3	Ground staff or passenger(s) struck by aircraft	0	0	0
		7.4	Loading error	0	0	0
		7.5	Bogus parts	0	0	0
A.8	Structure	8.1	Corrosion/fatigue	0	0	0
		8.2	Overload failure	0	-	~
		8.3	Flutter	0	0	0
A.9	Infrastructure	9.1	Incorrect, inadequate or misleading information to crew	0	-	-
		9.2	Inadequate airport support	0	2	7
A.10	Design	10.1	Design shortcomings	0	2	7
		10.2	Unapproved modification	0	0	0
		10.3	Manufacturing defect	0	0	0
A.11	Performance	11.1	Unable to maintain speed/height	0	0	0
		11.2	Aircraft becomes uncontrollable	0	0	0
A.12	Other	12.1	Caused by other aircraft	0	0	0
		12.2	Nonadherence to cabin safety procedures	C	C	C

<ul> <li>B.1 Aircraft systems</li> <li>B.2 ATC/Ground aids</li> <li>B.3 Environmental</li> <li>B.4 Crew</li> <li>B.5 Infrastructure</li> <li>B.6 Other</li> <li>B.6 Other</li> <li>C Consequence</li> <li>C.1 Controlled flight ir</li> <li>C.2 Collision with terr</li> </ul>	stems 1.1 1.2 Ind aids 2.1 Intal 3.1 3.3 3.3 4.1 4.1 4.2 6.1 6.1	Nonfitment of presently available safety equipment (ground proximity warning (system, traffic-alert and collision avoidance system, wind-shear warning, etc.) Failure/inadequacy of safety equipment Lack of air traffic control Lack of ground aids Poor visibility Weather Runway condition (ice, slippery, standing water, etc.) Training inadequate Presented with situation beyond training Failure in crew resource management (cross-check/coordinate) Incorrect/inadequate Presented use Failure in an angement failure in a failure in the anagement failure in the failure in the anagement failure in the anageme	nent (ground proximity warning /stem, wind-shear warning, etc.) r, etc.) theck/coordinate)	∞ οού4νο∞-ω-4α
	spin –	adequ ir traff round jility conditi nadec d with crew finade mana te regu	r, etc.) heck/coordinate)	οου 4 Γ ο ∞ - ω - 4 (
	spia –	ir traff round bility conditi nadec d with crew finade mana te regu	r, etc.) heck/coordinate)	ο ιο 4 Γ ο α - α - 4 α
	_	round pility conditi nadec d with d with crew finade mana te regu	r, etc.) heck/coordinate)	50 4 ア イ イ Ο ∞ イ ∞ イ 4 0
	_	ility sonditi d with crew finade mana te regu	r, etc.) heck/coordinate)	4 ア ← ← O ∞ ← ∞ ← 4 (
		condition of with crew finade mana te regu	r, etc.) heck/coordinate)	アイイ 〇 8 7 8 7 4 (
		Runway condition (ice, slippery, standing water Training inadequate Presented with situation beyond training Failure in crew resource management (cross-cl Incorrect/inadequate procedures Company management failure Inadequate regulation Inadequate regulatory oversight	r, etc.) theck/coordinate)	
		Training inadequate Presented with situation beyond training Failure in crew resource management (cross- Incorrect/inadequate procedures Company management failure Inadequate regulation Inadequate regulatory oversight	heck/coordinate)	- Ο ∞ - η - 4 (
		Presented with situation beyond training Failure in crew resource management (cross-cl Incorrect/inadequate procedures Company management failure Inadequate regulation Inadequate regulatory oversight	heck/coordinate)	0 ∞ ← ल ← 4 (
		Failure in crew resource management (cross-cl Incorrect/inadequate procedures Company management failure Inadequate regulation Inadequate regulatory oversight	heck/coordinate)	∞ ← ∾ ← 4 (
		Incorrect/inadequate procedures Company management failure Inadequate regulation Inadequate regulatory oversight		← m ← 4 (
	5.2 5.3 6.1	Company management failure Inadequate regulation Inadequate regulatory oversight		€ ← 4 ¢
	5.3 5.4 6.1	Inadequate regulation Inadequate regulatory oversight		- 4 (
	5.4 6.1	Inadequate regulatory oversight		4 (
	6.1			(
		Illegal/unauthorized/drug smuggling flight		0
	ince		Number	Number of Times Cited in Accidents
	Controlled flight into terrain (CFIT)			6
	Collision with terrain/water/obstacle			5
	sion			0
C.4 Ground coll	Ground collision with other aircraft			<b>-</b>
C.5 Ground coll	Ground collision with object/obstacle			<b>~</b>
C.6 Loss of con	Loss of control in flight			-
C.7 Fuel exhaustion	stion			0
C.7 Overrun				S
C.9 Undershoot	xt			5
C.10 Structural failure	failure			0
C.11 Postimpact fire	t fire			ო
C.12 Fire/smoke	Fire/smoke during operation			<b>-</b>
C.13 Emergency	Emergency evacuation difficulties			0
C.14 Forced land	Forced landing — land or water			0
C.15 Other cause	Other cause of fatality			0

				Number	Number of Times Cited in Accidents	ccidents
	<b>Causal Factor</b>			Primary	Causal	Total
1	Aircraft systems	1.1	System failure — affecting controllability	-	7	e
		1.2	System failure — flight deck information	~	5	9
		1.3	System failure — other	0	4	4
	ATC/Ground aids	2.1	Incorrect or inadequate instruction/advice	0	4	4
		2.2	Misunderstood/missed communication	0	<del></del>	-
		2.3	Failure to provide separation in the air	0	<del>.</del>	-
		2.4	Failure to provide separation on the ground	0	<del></del>	-
		2.5	Ground aid malfunction or unavailable	0	2	7
	Environmental	3.1	Structural overload	0	0	0
		3.2	Wind shear/upset/turbulence	ო	S	ω
		3.3	lcing	~	ю	4
		3.4	Wake turbulence — aircraft spacing	0	0	0
		3.5	Volcanic ash/sand/precipitation, etc.	0	2	7
		3.6	Birds	0	0	0
		3.7	Lightning	-	0	-
		3.8	Runway condition unknown to crew	0	<del>.                                    </del>	-
	Crew	4.1	Lack of positional awareness in the air	16	19	35
		4.2	Lack of positional awareness the on ground	0	0	0
		4.3	Lack of awareness of circumstances in flight	0	-	-
		4.4	Incorrect selection on instrument/navaid	-	0	-
		4.5	Action on wrong control/instrument	0	0	0
		4.6	Slow/delayed action	0	ю	ю
		4.7	Omission of action/inappropriate action	14	22	36
		4.8	"Press-on-itis"	7	10	17
		4.9	Failure in crew resource management (cross-check/coordinate)	4	14	18
		4.10	Poor professional judgment/airmanship	б	13	16
		4.11	Disorientation or visual illusion	-	-	7
		4.12	Fatigue	0	0	0
		4.13	State of mind	0	<del>.                                    </del>	-
		4.14	Interaction with automation	0	0	0
		4.15	Fast and/or high on approach	0	8	8
		116	Slow and/or low on annoach	C	6	22

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				Numbe	Number of Times Cited in Accidents	Accidents
۲	Causal Factor			Primary	Causal	Total
		4.17	Loading incorrect	-	2	m
		4.18	Flight handling	16	17	33
		4.19	Lack of qualification/training/experience	0	9	9
		4.20	Incapacitation/medical or other factors reducing crew performance	0	2	7
		4.21	Failure in look-out	۲-	2	ო
		4.22	Deliberate nonadherence to procedures	7	7	ი
A.5	Engine	5.1	Engine failure or malfunction	0	5	5
		5.2	Propeller failure	<del>.</del>	0	4
		5.3	Damage due to noncontainment	7	0	7
		5.4	Fuel contamination	0	0	0
		5.5	Engine failure simulated	0	-	-
A.6	Fire	6.1	Engine fire or overheat	0	4	4
		6.2	Fire due to aircraft systems	0	0	0
		6.3	Fire — other cause	~	0	-
		6.4	Postimpact fire	0	11	11
A.7	Maintenance/Ground handling	7.1	Failure to complete due maintenance	0	0	0
		7.2	Maintenance or repair error/oversight/inadequacy	~	4	5
		7.3	Ground staff or passenger(s) struck by aircraft	0	0	0
		7.4	Loading error	~	2	ю
		7.5	Bogus parts	0	0	0
A.8	Structure	8.1	Corrosion/fatigue	~	-	2
		8.2	Overload failure	0	ო	ო
		8.3	Flutter	0	-	-
A.9	Infrastructure	9.1	Incorrect, inadequate or misleading information to crew	0	2	7
		9.2	Inadequate airport support	0	4	4
A.10	Design	10.1	Design shortcomings	7	6	11
		10.2	Unapproved modification	0	0	0
		10.3	Manufacturing defect	0	0	0
A.11	Performance	11.1	Unable to maintain speed/height	0	4	4
		11.2	Aircraft becomes uncontrollable	0	с	С
A.12	Other	12.1	Caused by other aircraft	0	0	0
		100	Nonacharance to cabin safaty procedures	c	c	C

	Factors a	ind Con	Appendix 4.3 Factors and Consequences Attributed to 84 Fatal Approach-and-landing Accidents in Western-built Turboprops (continued)	nts in
В	<b>Circumstantial Factor</b>		Number of	Number of Times Cited in Accidents
B.1	Aircraft systems	1.1	Nonfitment of presently available safety equipment (ground-proximity warning system, traffic-alert and collision avoidance system, wind-shear warning, etc.)	38
			Failure/inadequacy of safety equipment	ю
B.2	Air traffic control/Ground aids	2.1 L	Lack of air traffic control	-
		2.2 L	Lack of ground aids	22
B.3	Environmental	_	Poor visibility	25
		-	Weather	41
			Runway condition (ice, slippery, standing water, etc.)	Ω
B.4	Crew	•	Training inadequate	7
			Presented with situation beyond training	-
		4.3 F	Failure in crew resource management (cross-check/coordinate)	37
B.5	Infrastructure	5.1	Incorrect/inadequate procedures	7
		5.2 (	Company management failure	21
		5.3	Inadequate regulation	8
		5.4	Inadequate regulatory oversight	22
B.6	Other	6.1	Illegal/unauthorized/drug smuggling flight	0
υ	Consequence		Number of	Number of Times Cited in Accidents
с.	Controlled flight into terrain (CFIT)	(LI		34
C.2	Collision with terrain/water/obstacle	acle		42
C.3	Midair collision			-
C.4	Ground collision with other aircraft	aft		2
C.5	Ground collision with object/obstacle	tacle		2
C.6	Loss of control in flight			32
C.7	Fuel exhaustion			0
C.8	Overrun			5
C.9	Undershoot			14
C.10	Structural failure			З
C.1	Postimpact fire			15
C.12	Fire/smoke during operation			2
C.13	Emergency evacuation difficulties	Sé		4
C.14	Forced landing — land or water			2
C.15	Other cause of fatality			£
Leve	Level of confidence	51 High	27 Medium 4 Low 2 Insufficient information	

				Numb	Number of Total Cited in Accidents	Accidents
	Causal Factor			Primary	Causal	Total
A.1	Aircraft systems	1.1	System failure — affecting controllability	0	0	0
		1.2	System failure — flight deck information	0	0	0
		1.3	System failure — other	0	0	0
A.2	Air traffic control/Ground Aids	2.1	Incorrect or inadequate instruction/advice	0	0	0
		2.2	Misunderstood/missed communication	0	0	0
		2.3	Failure to provide separation in the air	0	0	0
		2.4	Failure to provide separation on the ground	0	0	0
		2.5	Ground aid malfunction or unavailable	0	0	0
A.3	Environmental	3.1	Structural overload	0	0	0
		3.2	Wind shear/upset/turbulence	0	0	0
		3.3	Icing	~	2	ო
		3.4	Wake turbulence — aircraft spacing	0	0	0
		3.5	Volcanic ash/sand/precipitation, etc.	0	ო	ო
		3.6	Birds	0	0	0
		3.7	Lightning	0	0	0
		3.8	Runway condition unknown to crew	0	0	0
A.4	Crew	4.1	Lack of positional awareness in the air	2	4	9
		4.2	Lack of positional awareness the on ground	0	0	0
		4.3	Lack of awareness of circumstances in flight	0	0	0
		4.4	Incorrect selection on instrument/navaid	0	0	0
		4.5	Action on wrong control/instrument	0	0	0
		4.6	Slow/delayed action	0	~	-
		4.7	Omission of action/inappropriate action	ю	7	5
		4.8	"Press-on-itis"	9	7	8
		4.9	Failure in crew resource management (cross-check/coordinate)	0	0	0
		4.10	Poor professional judgment/airmanship	0	С	e
		4.11	Disorientation or visual illusion	0	0	0
		4.12	Fatigue	0	0	0
		4.13	State of mind	0	0	0
		4.14	Interaction with automation	0	0	0
		4.15	Fast and/or high on approach	0	0	0
		4.16	Slow and/or low on approach	C	ſ	LC.

			Eastern-pulit lurboprops (continued)			
				Numbe	Number of Times Cited in Accidents	Accidents
۲	Causal Factor			Primary	Causal	Total
		4.17	Loading incorrect	0	0	0
		4.18	Flight handling	4	3	4
		4.19	Lack of qualification/training/experience	0	0	0
		4.20	Incapacitation/medical or other factors reducing crew performance	0	0	0
		4.21	Failure in look-out	0	0	0
		4.22	Deliberate nonadherence to procedures	£	က	4
A.5	Engine	5.1	Engine failure or malfunction	0	0	0
		5.2	Propeller failure	0	0	0
		5.3	Damage due to noncontainment	0	0	0
		5.4	Fuel contamination	0	0	0
		5.5	Engine failure simulated	0	0	0
A.6	Fire	6.1	Engine fire or overheat	0	0	0
		6.2	Fire due to aircraft systems	0	0	0
		6.3	Fire — other cause	0	0	0
		6.4	Postimpact fire	0	2	2
A.7	Maintenance/Ground handling	7.1	Failure to complete due maintenance	0	0	0
		7.2	Maintenance or repair error/oversight/inadequacy	0	0	0
		7.3	Ground staff or passenger(s) struck by aircraft	0	0	0
		7.4	Loading error	4	0	-
		7.5	Bogus parts	0	0	0
A.8	Structure	8.1	Corrosion/fatigue	0	0	0
		8.2	Overload failure	0	0	0
		8.3	Flutter	0	0	0
A.9	Infrastructure	9.1	Incorrect, inadequate or misleading information to crew	4	~	2
		9.2	Inadequate airport support	0	~	-
A.10	Design	10.1	Design shortcomings	0	0	0
		10.2	Unapproved modification	0	0	0
		10.3	Manufacturing defect	0	0	0
A.11	Performance	11.1	Unable to maintain speed/height	0	0	0
		11.2	Aircraft becomes uncontrollable	0	-	-
A.12	Other	12.1	Caused by other aircraft	0	0	0
		12.2	Nonadherence to cabin safety procedures	C	C	C

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	Factors a	and Cor	Appendix 4.4 Factors and Consequences Attributed to 19 Fatal Approach-and-landing Accidents in Eastern-built Turboprops (continued)	
ш	<b>Circumstantial Factor</b>		Number of Times Cited in Accidents	ccidents
B.1	Aircraft systems	1.1	Nonfitment of presently available safety equipment (ground-proximity warning system, traffic-alert and collision avoidance system, wind-shear warning, etc.)	
		1.2	Failure/inadequacy of safety equipment	
B.2	Air traffic control/Ground aids	2.1	c control	
		2.2	Lack of ground aids 6	
B.3	Environmental	3.1	Poor visibility 5	
		3.2	Weather 8	
		3.3	Runway condition (ice, slippery, standing water, etc.) 0	
B.4	Crew	4.1	Training inadequate 0	
		4.2	Presented with situation beyond training	
		4.3	Failure in Crew resource management (cross-check/coordinate) 6	
B.5	Infrastructure	5.1	Incorrect/inadequate procedures	
		5.2	Company management failure 6	
		5.3	Inadequate regulation 0	
		5.4	Inadequate regulatory oversight 7	
B.6	Other	6.1	Illegal/unauthorized/drug smuggling flight	
υ	Consequence		Number of Times Cited in Accidents	ccidents
с.	Controlled flight into terrain (CFIT)	(E	Q	
C.2	Collision with terrain/water/obstacle	acle	0	
C.3	Midair collision		0	
0.4	Ground collision with other aircraft	aft	0	
C.5	Ground collision with object/obstacle	stacle	2	
C.6	Loss of control in flight		9	
C.7	Fuel exhaustion		2	
C.8	Overrun		2	
C.9	Undershoot		2	
C.10	Structural failure		0	
C.1	Postimpact fire		2	
C.12	Fire/smoke during operation		0	
C.13	Emergency evacuation difficulties	SS	0	
C.14	Forced landing — land or water		ŝ	
C.15	Other cause of fatality		0	
Leve	Level of confidence	8 High	7 Medium 1 Low 3 Insufficient information	

				Numbe	Number of Times Cited in Accidents	Accidents
۷	Causal Factor			Primary	Causal	Total
A.1	Aircraft systems	1.1	System failure — affecting controllability	-	0	÷
		1.2	System failure — flight deck information	4	4	7
		1.3	System failure — other	0	0	0
A.2	Air traffic control/Ground aids	2.1	Incorrect or inadequate instruction/advice	0	7	2
		2.2	Misunderstood/missed communication	0	0	0
		2.3	Failure to provide separation in the air	~	0	~
		2.4	Failure to provide separation on the ground	0	0	0
		2.5	Ground aid malfunction or unavailable	0	7	2
A.3	Environmental	3.1	Structural overload	0	0	0
		3.2	Wind shear/upset/turbulence	0	с	က
		3.3	Icing	2	0	7
		3.4	Wake turbulence — aircraft spacing	-	4	7
		3.5	Volcanic ash/sand/precipitation, etc.	0	2	7
		3.6	Birds	4	0	-
		3.7	Lightning	0	0	0
		3.8	Runway condition unknown to crew	0	0	0
A.4	Crew	4.1	Lack of positional awareness in the air	15	29	44
		4.2	Lack of positional awareness on the ground	0	0	0
		4.3	Lack of awareness of circumstances in flight	0	4	-
		4.4	Incorrect selection on instrument/navaid	ю	4	4
		4.5	Action on wrong control/instrument	0	0	0
		4.6	Slow/delayed action	0	7	7
		4.7	Omission of action/inappropriate action	23	11	34
		4.8	"Press-on-itis"	4	8	12
		4.9	Failure in crew resource management (cross-check/coordinate)	0	8	80
		4.10	Poor professional judgment/airmanship	4	15	19
		4.11	Disorientation or visual illusion	0	2	0
		4.12	Fatigue	0	5	5
		4.13	State of mind	0	4	-
		4.14	Interaction with automation	0	0	0
		4.15	Fast and/or high on approach	0	7	7
		011			۲c	30

				Numb	Number of Times Cited in Accidents	Accidents
	Causal Factor			Primary	Causal	Total
		4.17	Loading incorrect	0	5	5
		4.18	Flight handling	7	თ	16
		4.19	Lack of qualification/training/experience	-	5	9
		4.20	Incapacitation/medical or other factors reducing crew performance	2	0	2
		4.21	Failure in look-out	-	0	-
		4.22	Deliberate nonadherence to procedures	ю	ω	11
	Engine	5.1	Engine failure or malfunction	-	4	2
		5.2	Propeller failure	0	0	0
		5.3	Damage due to noncontainment	0	4	٢
		5.4	Fuel contamination	-	0	-
		5.5	Engine failure simulated	0	0	0
	Fire	6.1	Engine fire or overheat	0	2	7
		6.2	Fire due to aircraft systems	0	0	0
		6.3	Fire — other cause	0	0	0
		6.4	Postimpact fire	0	5	5
	Maintenance/Ground handling	7.1	Failure to complete due maintenance	0	0	0
		7.2	Maintenance or repair error/oversight/inadequacy	0	0	0
		7.3	Ground staff or passenger(s) struck by aircraft	0	0	0
		7.4	Loading error	0	0	0
		7.5	Bogus parts	0	0	0
	Structure	8.1	Corrosion/fatigue	0	0	0
		8.2	Overload failure	0	0	0
		8.3	Flutter	0	0	0
	Infrastructure	9.1	Incorrect, inadequate or misleading information to crew	-	2	ო
		9.2	Inadequate airport support	0	7	7
A.10	Design	10.1	Design shortcomings	0	4	-
		10.2	Unapproved modification	0	0	0
		10.3	Manufacturing defect	0	0	0
A.11	Performance	11.1	Unable to maintain speed/height	0	2	7
		11.2	Aircraft becomes uncontrollable	0	۲	-
A.12	Other	12.1	Caused by other aircraft	0	0	0
		12.2	Nonadharanca to cahin safatu nrocaduras	C	2	~

	Factors and Consequences Attributed	ences /		Appendix 4.5 to 76 Fatal Approach-and-landing Accidents in Business Jets (continued)	<b>Jets</b> (continued)
۵	<b>Circumstantial Factor</b>			Number of Times	Number of Times Cited in Accidents
B.1	Aircraft systems		Nonfitment of presently available safety equipment (ground-proximity warning system, traffic-alert and collision avoidance system, wind-shear warning, etc.)		44
		1.2	Failure/inadequacy of safety equipment		0
B.2	Air traffic control/Ground aids	2.1	Lack of air traffic control		-
		2.2	Lack of ground aids	2	25
B.3	Environmental	3.1	Poor visibility	2	26
		3.2	Weather	2	21
		3.3	Runway condition (ice, slippery, standing water, etc.)		3
B.4	Crew	4.1	Training inadequate		-
		4.2	Presented with situation beyond training		2
			Failure in crew resource management (cross-check/coordinate)		42
B.5	Infrastructure	5.1	Incorrect/inadequate procedures		5
		5.2	Company management failure	1	12
		5.3	Inadequate regulation		3
		5.4	Inadequate regulatory oversight	1	10
B.6	Other	6.1	Illegal/unauthorized/drug smuggling flight		2
ပ	Consequence			Number of Times	Number of Times Cited in Accidents
	Controlled flight into terrain (CFIT)	F		с С	39
C.2	Collision with terrain/water/obstacle	acle		e	30
C.3	Midair collision				2
C.4	Ground collision with other aircraft	aft			0
C.5	Ground collision with object/obstacle	tacle			5
C.6	Loss of control in flight			1	14
C.7	Fuel exhaustion				4
C.8	Overrun				5
C.9	Undershoot			1	12
C.10	Structural failure				0
C.11	Postimpact fire			2	20
C.12	Fire/smoke during operation				2
C.13	Emergency evacuation difficulties	S			0
C.14	Forced landing — land or water				-
C.15	Other cause of fatality				0
Leve	Level of confidence	35 High	29 Medium 10 Low 2 Ir	Insufficient information	

## **Aviation Statistics**

# NTSB Reports 1997 U.S. Airline Accident Fatalities Lowest Since 1993

The record improved between 1996 and 1997, even though passenger enplanements increased by 35 million in 1997. The number and rate of accidents classified as "major" by the U.S. National Transportation Safety Board also decreased from 1996 to 1997.

#### FSF Editorial Staff

The number of fatalities in accidents involving air carriers operating under U.S. Federal Aviation Regulations (FARs) Part 121 was substantially lower in 1997 than in 1996, according to preliminary statistics released by the U.S. National Transportation Safety Board (NTSB).

The improvement was particularly notable because new U.S. Federal Aviation Administration (FAA) rules that went into effect in March 1997 expanded the Part 121 category to include operations using aircraft with 10 or more seats operating scheduled passenger service. Total passenger enplanements on airlines flying under Part 121 increased from 590 million in 1996 to 625 million in 1997.

There were two passenger fatalities in Part 121 service in 1997, compared with 319 passenger fatalities in 1996 (Table 1, page 43). A third fatality occurred in 1997 when a ground crew member was killed by the nosewheel of a wide-body aircraft. The number of passenger fatalities was the lowest since 1993, when there were none.

Part 121 airlines had two major accidents and four serious accidents in 1997, compared with six major accidents and none classified as serious in 1996 (Table 2, page 44, which includes

NTSB category definitions). Major accidents dropped from 0.43 per million miles flown in 1996 to 0.13 in 1997.

There were 42 accidents on scheduled Part 121 air carriers including those added to the category during the year — in 1997, compared with 32 the previous year (Table 3, page 45). Among those carriers, the 1997 accident rate rose for all accidents (from 0.395 per 100,000 departures in 1996 to 0.442 per 100,000 departures in 1997), but declined for fatal accidents (from 0.037 per 100,000 departures in 1996 to 0.032 per 100,000 departures in 1997).

Nonscheduled (charter) Part 121 airlines had seven accidents, one of them fatal, in 1997 (Table 4, page 46). That compared with six accidents, two of which were fatal, in 1996. The Part 121 nonscheduled airline accident rate increased from 1.59 per 100,000 departures in 1996 to 1.87 per 100,000 departures in 1997, but the Part 121 nonscheduled airline fatal accident rate declined from 0.53 per 100,000 departures to 0.27 per 100,000 departures during the same period.

Because random variation is an ever-present factor in the relatively small annual numbers of aviation accidents, changes from one year to the next may not be statistically significant.

# Table 1Passenger Injuries and Injury Rates, 1982 through 1997,For U.S. Air Carriers Operating Under FARs Part 121\*

	Passenger	Passenger	Total Passenger Enplanements	Million Passenger Enplanements per
Year	Fatalities	Serious Injuries	(millions)	Passenger Fatality
1982	210	17	299	1.4
1983	8	8	325	40.6
1984	1	6	352	352.0
1985	486	20	390	0.8
1986	4	23	427	106.8
1987	213	39	458	2.2
1988	255	44	466	1.8
1989	259	55	468	1.8
1990	8	23	483	60.4
1991	40	19	468	11.7
1992	26	14	494	19.0
1993	0	7	505	No Fatalities
1994	228	16	545	2.4
1995	152	15	561	3.7
1996	319	16	590	1.8
See note bel	ow			
1997	2	21	625	312.5

\*Since March, 20, 1997, includes aircraft with 10 or more seats formerly operated under Part 135.

FARs – U.S. Federal Aviation Regulations

Note: Injuries exclude flight crew and cabin crew.

Source: U.S. National Transportation Safety Board

# Table 2Accidents and Accident Rates by NTSB Classification, 1982 through 1997,For U.S. Air Carriers Operating Under FARs Part 121\*

	Accidents			Acc		cidents per Million Hours Flown			
Year	Major	Serious	Injury	Damage	Aircraft Hours Flown (millions)	Major	Serious	Injury	Damage
1982	3	4	6	5	7.040	0.426	0.568	0.852	0.710
1983	4	2	9	8	7.299	0.548	0.274	1.233	1.096
1984	2	2	7	5	8.165	0.245	0.245	0.857	0.612
1985	8	2	5	6	8.710	0.918	0.230	0.574	0.689
1986	4	0	14	6	9.976	0.401	0.000	1.403	0.601
1987	5	1	12	16	10.645	0.470	0.094	1.127	1.503
1988	4	2	13	10	11.141	0.359	0.180	1.167	0.898
1989	8	4	6	10	11.275	0.710	0.355	0.532	0.887
1990	4	3	10	7	12.150	0.329	0.247	0.823	0.576
1991	5	2	10	9	11.781	0.424	0.170	0.849	0.764
1992	3	3	10	2	12.360	0.243	0.243	0.809	0.162
1993	1	2	12	8	12.706	0.079	0.157	0.944	0.630
1994	4	0	12	7	13.124	0.305	0.000	0.914	0.533
1995	3	2	14	17	13.510	0.222	0.148	1.036	1.258
1996	6	0	18	14	13.963	0.430	0.000	1.289	1.003
See no	te below								
1997	2	4	24	19	15.290	0.131	0.262	1.570	1.243

\*Since March 20, 1997, includes aircraft with 10 or more seats formerly operated under Part 135.

FARs - U.S. Federal Aviation Regulations

NTSB - U.S. National Transportation Safety Board

#### NTSB Accident Classifications:

Major: an accident in which any of three conditions is met:

• A Part 121 aircraft was destroyed;

• There were multiple fatalities; or,

• There was one fatality and a Part 121 aircraft was substantially damaged.

Serious: an accident in which either of two conditions is met:

- There was one fatality without substantial damage to a Part 121 aircraft; or,
- There was at least one serious injury and a Part 121 aircraft was substantially damaged.

Injury: A nonfatal accident with at least one serious injury and without substantial damage to a Part 121 aircraft.

Damage: An accident in which no person was killed or seriously injured, but in which any aircraft was substantially damaged.

Source: U.S. National Transportation Safety Board

Year         All         Fatal         Total         Aboard         Flight Hours         Miles Flown         Departures         All         I           1982         16         4         234         222         6,697,770         2,806,885,000         5,162,346         0.224         0           1983         22         4         15         14         6,914,969         2,920,909,000         5,162,346         0.224         0           1983         22         4         7,736,037         3,258,910,000         5,35,562         0.318         0         2206           1984         13         1         4         4         7,736,037         3,258,910,000         5,162,346         0.224         0         2066,076         0.168           1985         21         2         5         4         0,495,158         3,829,129,000         0,216         0.168         0.224         0         2016         0.211         0         2011         1         2011         201         2011         0.211         0         2011         0         2011         2011         0.211         0         2013         0.226         0.316         0.267         0         2013         223         224,755 </th <th>Eatal All</th> <th>Fatal All</th> <th>Fatal</th>	Eatal All	Fatal All	Fatal
16         4         234         222         6,697,770         2,806,885,000         5,162,346         0.224           22         4         15         14         6,914,969         2,920,909,000         5,162,346         0.224           13         1         4         7,736,037         3,258,910,000         5,666,076         0.168           17         4         197         196         8,265,332         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,829,129,000         7,293,025         0.316           21         2         5         4         9,495,158         3,829,129,000         7,934,575         0.211           229         10,115,407         4,125,874,000         7,293,025         0.306         0.206           238         239         12         10,597,922         4,260,785,000         7,267,341         0.224           238         12         <			
22         4         15         14         6,914,969         2,920,909,000         5,235,262         0.318           13         1         4         7,736,037         3,258,910,000         5,666,076         0.168           17         4         197         196         8,265,332         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,829,129,000         6,928,103         0.201           21         2         5         4         9,495,158         3,829,129,000         6,968,893         0.206           21         2         5         4         9,495,158         3,829,129,000         7,983,002         0.016           21         2         5         4         9,495,158         3,829,126,000         7,293,025         0.306           28         3         285         274         10,521,052         4,337,234,000         7,267,341         0.267           28         131         130         10,597,922         4,337,234,000         7,365,761         0.191           25         4         6         33         11,732,025         4,337,234,000         7,567,341         0.267           25<	4 0.045 0.0053	0.0011 0.291	0.058
13         1         4         4         7,736,037         3,258,910,000         5,666,076         0.168           17         4         197         196         8,265,332         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,829,129,000         6,928,103         0.216           21         2         5         4         9,495,158         3,829,129,000         6,928,103         0.206           32         4         231         229         10,115,407         4,125,874,000         7,293,025         0.306           32         8         131         130         10,597,922         4,260,785,000         7,293,025         0.306           28         3         211         130         10,597,922         4,360,785,000         7,267,341         0.257           28         3         131         130         10,597,922         4,337,234,000         7,267,341         0.226           26         4         8         11,139,166         4,558,537,000         7,565,761         0.191           27         1         1         1         1         1         0         1         0.224 <tr< td=""><td></td><td></td><td></td></tr<>			
17         4         197         196         8,265,332         3,452,753,000         6,068,893         0.206           21         2         5         4         9,495,158         3,829,129,000         6,928,103         0.211           32         4         231         229         10,115,407         4,125,874,000         7,293,025         0.306           32         4         231         229         10,115,407         4,125,874,000         7,347,575         0.306           28         3         285         274         10,521,052         4,260,785,000         7,347,575         0.306           28         3         131         130         10,597,922         4,337,234,000         7,347,575         0.226           24         8         131         130         10,597,922         4,337,234,000         7,795,761         0.191           22         4         6         39         12         11,524,726         4,689,287,000         7,795,761         0.191           25         4         33         31         11,732,026         4,689,287,000         7,795,761         0.191           26         4         33         11,732,026         4,782,825,000         7,512,337	8 0.013 0.0040	0.0003 0.229	9 0.018
21       2       5       4       9,495,158       3,829,129,000       6,928,103       0.211         32       4       231       229       10,115,407       4,125,874,000       7,293,025       0.306         28       3       285       274       10,521,052       4,260,785,000       7,347,575       0.257         28       3       285       274       10,597,922       4,337,234,000       7,293,025       0.306         24       8       131       130       10,597,922       4,337,234,000       7,267,341       0.226         25       4       6       39       12       11,524,726       4,689,287,000       7,795,761       0.191         26       39       12       11,524,726       4,689,287,000       7,503,873       0.224         25       4       62       49       11,139,166       4,558,537,000       7,503,873       0.224         26       1       1       0       11,732,026       4,782,825,000       7,515,373       0.136         27       1       1       0       11,981,347       4,936,067,000       7,721,870       0.136         28       1       1       0       11,981,347       4,936,060	3 0.048 0.0049	0.0012 0.280	0.066
32       4       231       229       10,115,407       4,125,874,000       7,293,025       0.306         28       3       285       274       10,521,052       4,260,785,000       7,347,575       0.257         24       8       131       130       10,597,922       4,337,234,000       7,347,575       0.256         22       6       39       12       11,524,726       4,689,287,000       7,795,761       0.191         25       4       62       49       11,139,166       4,558,537,000       7,795,761       0.191         25       1       1       0       11,732,026       4,558,537,000       7,503,873       0.224         26       49       11,139,166       4,558,537,000       7,515,373       0.136         27       1       1       0       11,732,026       4,782,825,000       7,515,373       0.136         27       1       1       0       11,732,026       4,782,825,000       7,721,870       0.136         28       1       1       1       0       11,981,347       4,936,067,000       7,721,870       0.146         29       237       12,292,356       5,112,633,000       7,824,802       0.146 <td>1 0.011 0.0052</td> <td>0.0003 0.289</td> <td>9 0.014</td>	1 0.011 0.0052	0.0003 0.289	9 0.014
28       3       285       274       10,521,052       4,260,785,000       7,347,575       0.257         24       8       131       130       10,597,922       4,337,234,000       7,267,341       0.226         22       6       39       12       11,524,726       4,689,287,000       7,795,761       0.191         25       4       62       49       11,139,166       4,558,537,000       7,503,873       0.226         16       4       33       31       11,732,026       4,782,825,000       7,515,373       0.136         22       1       1       0       11,39,166       4,558,537,000       7,515,373       0.136         22       1       1       0       11,732,026       4,782,825,000       7,515,373       0.136         22       1       1       0       11,732,026       4,782,825,000       7,721,870       0.136         23       33       31       11,732,026       5,112,633,000       7,721,870       0.136         34       2       166       160       12,776,679       5,328,969,000       8,105,570       0.146         33       342       342       13,188,456       5,499,206,000       8,105,570 <td>3 0.030 0.0075</td> <td>0.0007 0.425</td> <td>0.041</td>	3 0.030 0.0075	0.0007 0.425	0.041
24       8       131       130       10,597,922       4,337,234,000       7,267,341       0.226         22       6       39       12       11,524,726       4,689,287,000       7,795,761       0.191         25       4       62       49       11,139,166       4,558,537,000       7,503,873       0.224         16       4       33       31       11,732,026       4,782,825,000       7,515,373       0.136         22       1       1       0       11,391,347       4,936,067,000       7,515,373       0.136         22       1       1       0       11,732,026       5,112,633,000       7,721,870       0.136         23       33       11,732,026       5,112,633,000       7,721,870       0.136         34       2.39       2.37       12,292,356       5,112,633,000       7,824,802       0.146         34       2       166       160       12,776,679       5,328,969,000       8,105,570       0.266         342       342       13,188,456       5,499,206,000       8,092,429       0.243	7 0.019 0.0063	0.0005 0.367	7 0.027
22       6       39       12       11,524,726       4,689,287,000       7,795,761       0.191         25       4       62       49       11,139,166       4,558,537,000       7,503,873       0.224         16       4       33       31       11,732,026       4,782,825,000       7,515,373       0.136         22       1       1       0       11,981,347       4,936,067,000       7,721,870       0.184         19       4       239       237       12,292,356       5,112,633,000       7,824,802       0.146         34       2       166       160       12,776,679       5,328,969,000       8,105,570       0.266         32       342       342       13,188,456       5,499,206,000       8,092,429       0.243	3 0.075 0.0055	0.0018 0.330	0.110
25       4       62       49       11,139,166       4,558,537,000       7,503,873       0.224         16       4       33       31       11,732,026       4,782,825,000       7,515,373       0.136         22       1       1       0       11,981,347       4,936,067,000       7,721,870       0.184         19       4       239       237       12,292,356       5,112,633,000       7,824,802       0.146         34       2       166       160       12,776,679       5,328,969,000       8,105,570       0.266         32       3       342       342       13,188,456       5,499,206,000       8,092,429       0.243	1 0.052 0.0047	0.0013 0.282	2 0.077
16         4         33         31         11,732,026         4,782,825,000         7,515,373         0.136           22         1         1         0         11,981,347         4,936,067,000         7,515,373         0.136           19         4         239         237         12,292,356         5,112,633,000         7,824,802         0.146           34         2         166         160         12,776,679         5,328,969,000         8,105,570         0.266           32         342         342         13,188,456         5,499,206,000         8,092,429         0.243	4 0.036 0.0055	0.0009 0.333	3 0.053
22     1     1     0     11,981,347     4,936,067,000     7,721,870     0.184       19     4     239     237     12,292,356     5,112,633,000     7,824,802     0.146       34     2     166     160     12,776,679     5,328,969,000     8,105,570     0.266       32     3     342     13,188,456     5,499,206,000     8,092,429     0.243	6 0.034 0.0033	0.0008 0.213	3 0.053
19         4         239         237         12,292,356         5,112,633,000         7,824,802         0.146           34         2         166         160         12,776,679         5,328,969,000         8,105,570         0.266           32         3         342         13,188,456         5,499,206,000         8,092,429         0.243	4 0.008 0.0045	0.0002 0.285	5 0.013
34 2 166 160 12,776,679 5,328,969,000 8,105,570 0.266 32 3 342 13,188,456 5,499,206,000 8,092,429 0.243 Intes helow	3 0.033 0.0035	0.0008 0.230	0.051
32 3 342 13,188,456 5,499,206,000 8,092,429 0.243	s 0.016 0.0064	0.0004 0.419	9 0.025
ae intes helow	3 0.023 0.0058	0.0005 0.395	5 0.037
1997 42 3 3 2 14,500,000 6,084,011,000 9,500,000 0.290	0.021 0.0069	0.0005 0.442	2 0.032

Table 4

	Accidents	lents	Fatalities	ities				Accide 100 Flight	Accidents per 100,000 Flight Hours	Accidents per 1,000,000 Miles Flown	nts per ),000 Flown	Accide 100 Depa	Accidents per 100,000 Departures
Year	AII	Fatal	Total	Aboard	Flight Hours	<b>Miles Flown</b>	Departures	AII	Fatal	AII	Fatal	AII	Fatal
1982	2	-	-	~	342,555	131,628,000	188,787	0.584	0.292	0.0152	0.0076	1.059	0.530
1983	-	0	0	0	383,830	148,409,000	209,112	0.261	•	0.0067	•	0.478	•
1984	ю	0	0	0	429,087	169,153,000	232,776	0.699	•	0.0177	•	1.289	•
1985	4	ю	329	329	444,562	178,264,000	237,866	0.900	0.675	0.0224	0.0168	1.682	1.261
1986	ю	<del>ر</del>	ę	С	480,946	188,497,000	273,924	0.624	0.208	0.0159	0.0053	1.095	0.365
1987	2	<del>.</del>	-	<del>.</del>	529,785	234,647,000	308,348	0.378	0.189	0.0085	0.0043	0.649	0.324
1988	-	0	0	0	619,496	242,641,000	368,486	0.161	•	0.0041	•	0.271	•
1989	4	e	147	146	676,621	267,849,000	378,153	0.591	0.443	0.0149	0.0112	1.058	0.793
1990	2	0	0	0	625,390	258,545,000	296,545	0.320	•	0.0077	•	0.674	•
1991	-	0	0	0	641,444	266,287,000	311,002	0.156	•	0.0038	•	0.322	•
1992	2	0	0	0	627,689	272,091,000	365,334	0.319	•	0.0074	•	0.547	•
1993	-	0	0	0	724,859	313,402,000	351,303	0.138	•	0.0032	•	0.285	•
1994	4	0	0	0	831,959	365,485,000	417,525	0.481	•	0.0109	•	0.958	•
1995	2	~	2	2	733,387	322,246,000	359,633	0.273	0.136	0.0062	0.0031	0.556	0.278
1996	9	2	38	Ø	774,436	344,192,000	377,512	0.775	0.258	0.0174	0.0058	1.589	0.530
1997	7	<del>.</del>	5	4	790,000	357,900,000	375,000	0.886	0.127	0.0196	0.0028	1.867	0.267
FARs – U.S. Federal Aviation Regulations	al Aviation	Regulations											
Notes:													
1997 data are preliminary.	iminary.												
Hours, miles and departures are compiled by the U.S. Federal Aviation Administration.	lepartures	are compiled	I by the U.S. F∉	ederal Aviation	Administration.								
Source: U.S. National Transportation Safety Board	l Transportat	tion Safety Boa	ard										

# Publications Received at FSF Jerry Lederer Aviation Safety Library

# Researchers Find That Redesigned Type III Exit Aids Evacuation in Test

New book offers comprehensive overview of communication navigation surveillance, air traffic management (CNS/ATM) system that will be the basis of the future air navigation system (FANS).

FSF Editorial and Library Staffs

#### **Reports**

*The Design and Evaluation of an Improvement to the Type III Exit Operating Mechanism.* Cobbett, A.M.; Jones, J.I.; Muir, H. U.K. Civil Aviation Authority (CAA) Paper no. 97006. September 1997. 69 pp. Tables, figures, appendices. Available through CAA.\*

The Department of Aerospace Technology at Cranfield University was commissioned by the CAA in 1994 to evaluate the ease of use of the operating mechanism of Type III exits, and thus their accessibility for emergency aircraft evacuation. Type III exits are used on a wide variety of civil aircraft. These exits are different from airframe main doors because they are not supported or attached to hinges or other mechanisms.

Previous research and accident evidence have shown that many passengers have experienced difficulty in operating Type III exits when evacuating an aircraft. The weight of the hatch can be a factor (as much as [30.4 kilograms] 67 pounds on certain wide-body aircraft), in addition to lack of space, obstructions and the average passenger's unfamiliarity with the operation of the hatch.

For this study, a modified design was developed. The new design's engineering was practical for application to Type III exit locations in both narrow-body and wide-body aircraft. Tests were conducted to compare the conventional design with the modified operating mechanism to study the ease with which study participants were able to evacuate the aircraft cabin in a simulated emergency. Seating configuration changes adjacent to the exit were also assessed to evaluate any influence on the use of the Type III exit. The research discussed in this paper showed that the time needed to exit the aircraft was significantly reduced using the modified Type III exit design compared with the conventional design.

Appendices: (A) Procedure for Selection of Shortlisted Concepts; (B) Consideration of Five Shortlisted Concepts; (C) Considerations Leading to Final Concept Selection; (D) Diagram of the Modified Type III Exit; (E) Diagrams of the Two Seating Configurations; (F) Safety Placards; (G) Questionnaire; (H) Transcript of Preflight Briefing; (I) Emergency Evacuation Scenarios; (J) Raw Evacuation Times and Participant Demographics. [Adapted from Introduction and Conclusions.]

*Personality Characteristics of Pre/Post-Strike Air Traffic Control Applicants.* Schroeder, David J.; Dollar, Carolyn S. U.S. Federal Aviation Administration (FAA) Office of Aviation Medicine. Report no. DOT/FAA/AM-97/17. July 1997. 20 pp. Tables, figures, references, appendix. Available through NTIS.\*\*

<u>Keywords:</u> Air Traffic Controller Applicants Personality Post-ATC Strike 16PF

For more than 30 years, the FAA has used the 16 Personality Factors (16PF) test to identify potential psychological difficulties in air traffic control specialist (ATCS) applicants. The 16PF test was developed in 1949 by R.R. Cattell to measure aspects of normal adult personality. Recently, changes in ATCS recruitment efforts and the effects of the air traffic controllers' strike in 1981 have altered the pool of applicants. Previous recruitment efforts focused on former military air traffic controllers, while subsequent efforts have focused on attracting more women and minority applicants. This report is designed to examine the relationship between the personality characteristics of a group of poststrike ATCS applicants, studied in 1984, with a 1974 study by Karson and O'Dell, using data collected from the 1960s and early 1970s. Besides this comparison, the 1984 data can also provide a baseline from which to evaluate the characteristics of new air traffic controllers expected to enter the work force after the year 2000.

Results of the 1984 study were found to be consistent with findings from the 1974 study despite demographic changes. Male and female applicants had very similar personality profiles, and were found to be brighter than the average individual. When compared with the general population, the study also revealed ATCS applicants to be less anxious and more emotionally stable, self-disciplined and assertive.

Appendix A consists of descriptive information for the factors from the 16PF test profile, Karson and O'Dell and the Administrator's manual for the 16PF. [Adapted from Introduction and Conclusions.]

*A Flexible Cabin Simulator.* Marcus, Jeffrey H. U.S. Federal Aviation Administration (FAA) Office of Aviation Medicine. Report No. DOT/FAA/AM-97/18. August 1997. 19 pp. Figures. Available through NTIS.\*\*

<u>Keywords:</u> Passenger Aircraft Evacuation Evacuation Experimental Cabin Simulator

Aircraft cabin simulators are frequently used to conduct experimental research on emergency passenger evacuation. Normally, these simulators are configured to represent a typical airline passenger cabin, with research subjects attempting to evacuate as quickly as possible. Aspects of cabin design (such as the width of aisles) and operational procedures are varied so that the goal of cabin evacuation in the shortest possible time can be studied.

Nevertheless, certain limitations exist with current cabin simulators, which are usually either retired aircraft or other special-purpose simulators that duplicate only a single or limited number of aircraft. Because of this, new designs such as multideck, multiaisle megatransports cannot be simulated, thus restricting necessary research. This report describes the requirements for a proposed flexible aircraft cabin simulator that is able to simulate any type of passenger aircraft cabin, from small commuter aircraft through jumbo transport. Features include a hydraulic positioning system, making door sill height adjustable; modular design, making it possible to fabricate cabin components such as exits; controlled interior and exterior lighting; and the use of nontoxic, vision-obscuring theatrical smoke. There is also a cabin-side pool to simulate an emergency water evacuation. Details and costs of the associated building are also discussed.

Contains many artist's conceptions of the proposed simulator and surrounding facility. [Adapted from Introduction and Summary.]

[See "Flexible Cabin Simulator Would Broaden Range of Cabin Evacuation Research," *Cabin Crew Safety*, July–August 1996.]

Designing Selection Tests for the Future National Airspace System Architecture. Broach, Dana. U.S. Federal Aviation Administration (FAA) Office of Aviation Medicine. Report no. DOT/FAA/AM-97/19. August 1997. 12 pp. Figures, references. Available through NTIS.\*\*

<u>Keywords:</u> Selection Air Traffic Control Specialist Electronics Technician Research Planning

There is a lack of empirical data that outlines the necessary abilities required to operate and maintain the emerging National Airspace System (NAS) architecture as described in the National Airspace Architecture version 2.0, produced by the FAA in 1996. This report describes the three-phase approach that the FAA is pursuing to identify the human abilities and performance requirements of the future NAS architecture, while addressing the challenges of cost, generational change and technological innovation in air traffic control and maintenance systems.

This effort involves the FAA Civil Aeromedical Institute (CAMI) Training and Organizational Research Laboratory's future selection-research program, which is designed to develop scientific tools and collect data to assess and evaluate the abilities likely to be required of future air traffic controllers, technicians and systems specialists. The first phase of the research program will develop a baseline profile describing the abilities required to use, operate and maintain the current NAS. The second phase will develop and apply scientific tools to identify changes in selection requirements in parallel with air traffic control and maintenance systems development. The third and final phase of the research program will develop, validate and deliver new personnel-selection technologies to reflect the human ability and performance requirements of the emerging NAS architecture. [Adapted from Introduction and Summary.] Aviation Safety: FAA Oversight of Repair Stations Needs Improvement. U.S. General Accounting Office (GAO). Report to Congressional Requesters, October 1997. Report no. GAO/ RCED-98-21. 91 pp. Tables, figures, appendices. Available through GAO.\*\*\*

Fleets operated by U.S. airlines and air cargo companies include more than 6,700 aircraft, almost 1,000 more than in 1990. Nearly half of the yearly maintenance, repair and renovation of this fleet is carried out by about 2,800 independent repair stations at a cost approaching US\$6.5 billion a year. These stations are located worldwide and can range from some which employ a small staff and fix a limited number of components, to others employing thousands of workers who do everything from routine engine maintenance to rebuilding entire airframes.

Repair stations have been part of the industry for decades, but their use has greatly increased recently because of the many new carriers that find it more economical to contract out much of their maintenance work instead of building and staffing their own facilities. There has been recent concern about U.S. Federal Aviation Administration (FAA) oversight of repair stations because work performed by repair stations has been identified as being a contributing cause in several aircraft accidents, notably the accident involving a ValuJet DC-9 that was destroyed by an engine fire on a runway in June 1995.

This report set out to examine the following questions: (1) What is the nature and scope of the oversight of repair stations conducted by the FAA?; (2) how well does the FAA follow up on repair station inspections to ensure that identified deficiencies in the stations' operations are corrected?; and (3) what steps has the FAA taken to improve oversight of repair stations?

The following recommendations are made: (1) Increase the use of locally based inspection teams for repair station inspections, particularly for large, complex repair stations, those with higher rates of noncompliance or those that meet predetermined risk indicators. Develop and use checklists or job aids to bring about greater comprehensiveness and standardization; (2) specify the documentation to be kept in repair station files to record inspection results and follow-up actions; (3) monitor the implementation of the strategy for improving the quality of the data for the FAA's new management information system; and (4) expedite efforts to update regulations for the oversight of repair stations, while establishing and meeting schedules for completing the updates.

Includes three appendices: (I) Objective, Scope and Methodology, which outlines the airlines and repair stations included in this review; (II) Survey Methodology; (III) Survey Questions and Responses; and (IV) Major Contributors to This Report. [Adapted from Executive Summary and Results in Brief.]

#### Books

*The Future Air Navigation System (FANS).* Galotti, Vincent P. Brookfield, Vermont, United States: Ashgate Publishing Company, 1997. 362 pp.

The communication navigation surveillance, air traffic management (CNS/ATM) environment of the 21st century promises great benefits as new air routes are opened and more dynamic and flexible flight operations are accommodated all over the world. This concept for a future air navigation infrastructure is being developed by the nations of the world in association with the International Civil Aviation Organization (ICAO).

Although the concept's implementation is progressing, only technical manuals exist to describe the system's concept. Galotti's book is the first of its kind, entirely dedicated to the CNS/ATM systems concept. Further, it describes the world's vision for the future air navigation system (FANS) covering not just technical issues, but also institutional, economic, labor and human factors issues as well. Each chapter includes a summary along with questions and exercises, which makes this book suitable as a text for technical schools, high schools and universities. Professionals who implement, operate and further develop the new system will also find it important and comprehensive. Contains an index.

The author currently works for ICAO in Montreal, Quebec, Canada, as a technical officer, air traffic management, and he has worked as an air traffic controller for the U.S. Federal Aviation Administration (FAA) in the New York Air Route Traffic Control Center. [Adapted from Introduction and Foreword.]

Aviation Safety and Pilot Control: Understanding and Preventing Unfavorable Pilot-Vehicle Interactions. National Research Council. Washington, D.C., United States: National Academy Press, 1997. 208 pp.

Aircraft-pilot coupling (APC) events usually occur when a pilot is occupied with a highly demanding "closed-loop" control task, such as during air-to-air refueling operations or approaches and landings, particularly if the pilot is concerned about bad weather, low on fuel or other circumstances. Adverse APC events are rare, unintended and unexpected oscillations or divergences of the pilot-aircraft system, and can cause mismatches between actual and expected aircraft responses.

Some recent accidents and incidents, both military and civilian, have been attributed to adverse APC. To address this situation, the National Research Council, at the request of the U.S. National Aeronautics and Space Administration (NASA), established the Committee on the Effects of Aircraft-Pilot Coupling on Flight Safety. The committee evaluated the current state of knowledge about adverse APC and the processes that may be used to eliminate it. This book consists of findings and recommendations developed by the committee based on the information it collected and analyzed.

Findings and recommendations were submitted for consideration to the U.S. Air Force, U.S. Navy and U.S. Army; NASA; and the U.S. Federal Aviation Administration (FAA). The committee concluded that in the short term, the risk presented by adverse APC could be reduced by increased awareness of APC possibilities and more disciplined application of existing tools and capabilities throughout the aircraft development, testing and certification process. Many advanced aircraft designs require new methods to address APC risk. To develop these new methods, the committee concluded that long-term efforts are needed in the area of APC assessment criteria, analysis tools and simulation capabilities.

Appendices: (A) Biographical Sketches of Committee Members; (B) Participants in Committee Meetings; (C) Details of Aircraft-Pilot Coupling Examples; and (D) Research. Also includes a glossary. [Adapted from Preface and Executive Summary.]

*When the Airlines Went to War.* Serling, Robert J. New York, New York, United States: Kensington Publishing Corp., 1997. 310 pp.

Robert J. Serling is a well-known aviation author who also wrote the bestseller, *The President's Plane is Missing. When the Airlines Went to War* tells the story of how America's domestic airlines, including American Airlines, Trans World Airlines, United Airlines and Pan American World Airways, contributed to the U.S. military war effort in World War II. Exchanging their civilian colors for olive drab, these domestic airlines gave up half their fleets and their most skilled pilots, mechanics and engineers. Extending their skills and endurance levels to the limit, crews carried cargo ranging from troops to ammunition, medicine, spies and dogsled teams. Aircraft were kept operating by mechanics who sometimes borrowed parts from visiting planes, or even fashioned parts from scrap metal and tin cans. The book describes what life was like for crews inside the transports, and for airmen on secret and dangerous missions across the globe. There are accounts of meetings between the airline owners and the staff of U.S. President Franklin Delano Roosevelt's White House as they developed the Air Transport Command (ATC) and Naval Air Transport Service (NATS).

The author gives grateful acknowledgment to Jerry Lederer, the President/Emeritus of Flight Safety Foundation, for providing background information on the development of the airlines' wartime training schools, which he helped to establish. [Adapted from inside cover and Acknowledgments].♦

#### Sources

\*U.K. Civil Aviation Authority (CAA) Printing and Publications Services Greville House 37 Gratton Road Cheltenham GL50 2BN England

\*\*National Technical Information Service (NTIS)
5285 Port Royal Road
Springfield, VA 22161 U.S.
(703) 487-4600

\*\*\*U.S. General Accounting Office (GAO) P.O. Box 6015 Gaithersburg, MD 20884-6015 U.S. Telephone: (202) 512-6000; Fax: (301) 258-4066

## **Updated Regulations and Reference Materials**

#### U.S. Federal Aviation Administration Advisory Circulars (ACs)

AC No.	Date	Title
183.29-1FF	12/18/97	Designated Engineering Representatives Consultant Directory. (Cancels AC 183.29-
		1EE, Designated Engineering Representatives, dated Dec. 18, 1996.)

#### **International Reference Updates**

	Il Information Publicat	tion (A.I.P.) Canada				
Amendment	No. Date					
2/98	23 April 1998	Updates the General, Aerodromes, Meteorology, Rules of the Air and Air Traffic Services, and Airmanship sections of the A.I.P.				
Airclaims						
Update No.	Date					
107	27 March 1998	Updates <i>Major Loss Record</i> . Worldwide aircraft accident summaries through early March 1998.				
Joint Aviati	Joint Aviation Authorities (JAA)					
Reference No	o. Date					
01/13-5	1 February 1998	Revision to JAA Administrative and Guidance Material — Section Three — Certification.				

## **Accident/Incident Briefs**

# Incorrect Altimeter Setting Puts Aircraft on Approach at 74 Meters above Field Elevation While Eight Kilometers from Runway

Emergency helicopter strikes power line, killing pilot, nurses and accident victim who was being transported to trauma center.

#### FSF Editorial Staff

The following information provides an awareness of problems through which such occurrences may be prevented in the future. Accident/incident briefs are based on preliminary information from government agencies, aviation organizations, press information and other sources. This information may not be entirely accurate.



#### Wind-shear Alert in Clear Weather

Boeing 767-300. Substantial damage. No injuries.

The aircraft was in the final stage of a manually flown, daylight instrument landing system (ILS) approach to an eastern U.S. airport. The weather was clear, with winds of (30 kilometers per hour [kph] gusting to 46 kph) 16 knots gusting to 25 knots. About five seconds before expected touchdown, at an altitude of nine meters (30 feet) above the ground, a wind-shear alert sounded in the cockpit.

There was no recorded aft movement of the aircraft's control column during the alert until about one second to two seconds before touchdown.

The aircraft touched down hard (+1.9 Gs) and bounced. While airborne, the aircraft's ground spoilers partially deployed and then

stowed again. The second touchdown was harder (+2.8 Gs), but the aircraft stayed on the ground and was brought to a halt on the runway.

The approach was flown by the copilot, who had 68 hours in type.

#### Pilot Aborts Takeoff Without Autothrottles

McDonnell Douglas MD-82. Substantial damage. No injuries.

The runway at the Asian airport was (3,300 meters) 10,800 feet long; it was wet from light rain and had been described as "slick."

During the takeoff, just before reaching  $V_1$ , the aircraft's autothrottles tripped off. The captain elected to abort the takeoff, but he was unable to stop the aircraft before the end of the runway.

The pilot steered the aircraft to the left, toward a taxiway, in an effort to avoid an overrun; but the aircraft began to skid sideways and came to rest on its fuselage, about (170 meters) 558 feet beyond the runway end.

#### Cargo Compartment Fire Forces Landing

#### Boeing 747. Minor damage. No injuries.

The aircraft was on a scheduled international flight when a fire occurred in the cargo section. The captain used the aircraft's emergency systems to extinguish the fire. He then requested clearance for an unscheduled landing. The aircraft landed without further incident at 0500 local time.

Airport officials said that the fire had been caused by an electrical fault, but gave no details. There were no casualties on board the aircraft.



## **Pilot Ignores Warning Horn**

Beech B100 King Air. Damage unknown. No injuries.

The pilot had landed 20 minutes earlier at a western U.S. airport; on his approach to the airport, there had been three green lights on the aircraft's instrument panel, indicating that the landing gear was down and locked.

While taxiing for takeoff, the landing-gear warning horn sounded. The pilot adjusted the squat switch to silence the horn, and then made a test flight to check the adjusted system.

During the subsequent landing, the left-main landing gear collapsed on rollout, and the aircraft veered off the runway and collided with a sign.

## Damage Happened after the Landing

Beech B200 King Air. Substantial damage. No injuries.

While en route, the pilot became concerned about his aircraft's fuel state and elected to divert. Weather was marginal, with a (214-meter) 700-foot ceiling and visibility of (488 meters) 1,600 feet in fog.

The pilot made an ILS approach, but landed about (1,000 meters) 3,281 feet short of the runway.

The aircraft had apparently suffered little or no damage. When the pilot decided to taxi forward onto the runway, the aircraft's nose wheel rolled into a hole and substantial damage occurred to the aircraft.

## **Cargo Aircraft Fails to Stay Airborne**

Fokker F-27. Aircraft destroyed. One fatal, five serious injuries.

The cargo-configured aircraft took off from Runway 06 at an African airport in daylight and visual meteorological conditions (VMC).

The aircraft's landing gear was seen to retract immediately after the aircraft became airborne. The aircraft then settled back onto the runway in a right-wing-low attitude, and the right wing and no. 2 propeller struck the ground.

The aircraft continued to slide on its fuselage, off the end of the runway and across rough ground, finally coming to rest about (300 meters) 984 feet beyond the end of the runway.

Areas under investigation as the possible causes of the accident include errors in the takeoff weight-and-balance calculations and the possibility of cargo shifting on takeoff.



**Crosswind Landing in Strong Winds Taxes Pilot** 

Cessna 650 Citation III. Substantial damage. No injuries.

Following a normal ILS approach to Runway 04 in daylight and clear weather, the aircraft touched down on its left-main landing gear. Then its right-main landing gear made contact, and the aircraft bounced into the air before touching down again.

After a further ground run of (91 meters to 122 meters) 300 feet to 400 feet, the left-main landing gear collapsed and the left wing hit the runway.

The wind was from 120 degrees at (46 kilometers per hour) 25 knots, a right-hand crosswind of almost 90 degrees.

## Airport Utility Vehicle Stalls On Runway, Hit by Landing Aircraft

Gulfstream Aerospace Gulfstream II. Aircraft destroyed. No injuries.

On a night landing in clear weather, the aircraft collided with an airport utility vehicle that had stalled on the runway.

The crew of the utility vehicle had been cleared onto Runway 31 about 40 minutes earlier to work on the runway centerline lights. Some time after that the vehicle became disabled. The aircraft had been cleared to land by the tower local controller when the aircraft was about (19 kilometers) 12 miles from the airport.

One of the men in the vehicle saw the approaching aircraft and radioed the tower that the vehicle was on the runway. After making more unsuccessful attempts to start the vehicle, the two men abandoned the vehicle and ran to safety.

The aircraft landed uneventfully. It was rolling out and reverse thrust had been applied when the tower instructed the aircraft to go around. The crew of the Gulfstream advised the tower that they had already landed.

Shortly thereafter, the crew of the Gulfstream saw the utility vehicle parked on the runway centerline. They tried to turn left to avoid the vehicle, but they were not successful; the right wing of the Gulfstream struck the utility vehicle.

## Loss of Engine Power Ends in Loss of Aircraft

Learjet 35A. Aircraft destroyed. No injuries.

The aircraft was taking off in daylight on Runway 21. As the aircraft approached  $V_1$ , the left engine lost power; the aircraft veered off the runway about (793 meters) 2,600 feet from where it began the takeoff.

The aircraft then became airborne and climbed to an altitude of (15 meters to 23 meters) 50 feet to 75 feet before settling back onto the runway surface about (305 meters) 1,000 feet farther down the runway.

The weather was visual meteorological conditions, with the wind from 260 degrees at (13 kilometers per hour gusting to 35 kilometers per hour) seven knots gusting to 19 knots.



## Bad Weather and High Terrain Prove Dangerous Combination

Unidentified light aircraft. Aircraft destroyed. Two fatalities.

The pilot was approaching his destination, a mountain airport in South America. When he learned that the airport was closed because of heavy rain and restricted visibility, the pilot was forced to make a 180-degree turn.

Air traffic controllers lost contact with the aircraft shortly after that. The next day the wreckage of the aircraft was found in the mountainous terrain. It was determined that after the Uturn, the aircraft flew into the mountain.

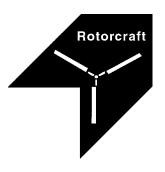
## Engine Overspeed Causes Aircraft to Leave Runway

Cessna 441. Aircraft destroyed. No injuries.

During the takeoff roll in daylight and clear weather, the aircraft's right engine began to overspeed. The aircraft veered to the left.

The pilot attempted to abort the takeoff, but the right wing lifted, and the aircraft departed the runway in a nose-down, left-wing-low attitude. Impact with the ground collapsed the landing gear, and the aircraft spun around several times before coming to a stop.

Fire destroyed the aircraft.



## Helicopter Clips Hedge in Forced Landing

Bell 206 LongRanger IV. Substantial damage. Five injuries.

The privately owned helicopter was required to make an offairport landing, during which the aircraft clipped a hedge and made contact with the ground. The five occupants of the helicopter, one of whom was seriously injured, were taken to the hospital.

## Impact with Power Pole Downs Helicopter

Unknown type. Aircraft destroyed. Three fatalities.

A four-member crew aboard the helicopter was stretching wire across a river when the helicopter contacted a power pole.

One of the helicopter rotors struck a worker on the power pole and knocked him to the ground, fatally injured. The helicopter then fell into the river. The impact with the water killed the pilot and one of the passengers. The two remaining passengers were taken to a hospital, where one was listed in serious condition. No one on the ground was hurt. The time of day and the weather at the time of the accident were not reported.

## Loss of Tail Rotor Sends Helicopter Out of Control

Unknown type. Aircraft destroyed. Two fatalities.

After losing its tail rotor, the helicopter plummeted nose-first into a field and burst into flames. Witnesses tried to pull the two occupants of the helicopter from the wreckage, but were repelled by the flames.

The identity of the two men in the helicopter and the helicopter's owner had not been established at the time of the accident report.

No information was given on the time the accident occurred or the weather at the time of the accident.

## Uncontained Engine Failure Damages Second Engine

Aérospatiale AS332L1 Super Puma. Aircraft destroyed. Twelve fatalities.

The crew of the Super Puma was transferring 10 passengers from a land base (200 kilometers) 108 nautical miles to a North Sea oil platform. Routine communications between the aircraft and the oil platform continued until five minutes before the helicopter's expected arrival time. About (31 kilometers) 17 nautical miles from its destination, the aircraft struck the sea. Unconfirmed reports indicate that an uncontained failure of the no. 2 engine's Bendix shaft. Debris from the no. 2 engine passed through the no. 1 engine and the cabin roof, and also damaged the helicopter flight controls. The crew lost control and the helicopter began to break up.

## Medevac Helicopter Destroyed by Medical-oxygen Cylinder Explosion

Bell 206L3 Long Ranger. Aircraft destroyed. One serious injury.

After arriving at the scene of an ultralight-aircraft accident, the pilot of the Long Ranger medical evacuation helicopter secured the aircraft's engine and electrical power. While the medical technicians attended to the injuries of the ultralight's occupants, the pilot prepared the helicopter for departure. Immediately after the pilot opened the valve of the medical oxygen-supply cylinder, which was housed in the luggage compartment, a large explosion occurred. Inspection revealed that the high-pressure hose that leads from the oxygen cylinder to the oxygen-pressure gauge in the aft cabin contained traces of welding slag and flux material. The hose failed because of internal burning at a point about (7.62 centimeters) three inches from the point at which the hose attaches to the cylinder.

## Long-line Operation Ends in Landing Accident

Aérospatiale SA 319B Astazou Alouette III. Aircraft substantially damaged. One minor injury.

The aircraft was moving an external load with a long line into a site located (1,983 meters) 6,500 feet above sea level. Not satisfied with his first approach to the landing area, the pilot waved off and approached from the opposite direction. As the aircraft descended on approach, the pilot increased the collective. The aircraft shuddered, rotor revolutions per minute (RPM) decayed and the rate of descent increased. After striking the ground, the helicopter rolled onto its right side. At the time of the report, it was suspected that the aircraft settled with power.

## Underslung Cable Complicates Landing Following Hydraulic-pressure Loss

Aérospatiale AS350B2 Ecureuil. Damage unknown. No injuries.

A geophysical survey was being conducted using equipment carried on an underslung cable and weighing (431 kilograms) 950 pounds. After the aircraft suffered an in-flight loss of hydraulic pressure, the pilot elected to return to base with the geophysical equipment still attached. When the pilot began to drop the underslung equipment to land the aircraft, the nose of the aircraft began to rise as tension was released from the cable.

The pilot turned the helicopter to land behind the equipment when tension unexpectedly returned to the cable and caused the geophysical equipment to be dragged through a snow drift. Control of the helicopter was momentarily lost, and the aircraft descended. The aircraft's tail stinger struck the ground and the helicopter ascended. The cable to the geophysical equipment came under tension again and the helicopter descended in a nose-low attitude over an embankment. The main rotors struck both the ground and the tailboom, but the aircraft did not roll over.

Inspection revealed that the hydraulic-pressure loss was caused by a failure of a hydraulic-pump drive belt at a seam in the belt. The belt, which is normally changed at 600 hours, had been in use for 250 hours at the time of the accident. The operator had inspected the belt's condition and tension daily prior to the accident.♦





# **Disaster Response Planning Workshop for Business Aviation**

June 18–19, 1998 **Atlanta Airport Hilton and Towers** Atlanta, Georgia, U.S.

#### Who Should Attend?

- Department managers (flight, maintenance, scheduling and administration);
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- Corporate security managers;
- Human resource/personnel managers;
- Public relations/communications managers;
- Risk/insurance and financial managers; and,
- Administrative managers.



#### Why Should You Attend?

- Develop your own disaster response plan-now!;
- Update your current disaster response plan (at least every other year):
- Increase the number of people in your department with skills and expertise in disaster response (one or two aren't enough);
- Improve corporate managers' understanding of the unique issues involved in an aviation-related disaster (you'll want all the help you can get); and,
- · Help your department's staff after a nonaviation disaster (automobile accident, fire or act of violence).



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